a multispecialty refinement panel of physicians to assist us in the review of the comments. The comments that we did not submit to panel review are discussed at the end of this section, as well as those comments that were reviewed by the panel. We invited representatives from each of the specialty societies from which substantive comments were received to attend a panel for discussion of the codes on which they had commented. The panel was moderated by our medical staff and consisted of the following voting members:

- One to two clinicians representing the commenting specialty or specialties, based upon our determination of those specialties which are most identified with the service(s) in question. Although commenting specialties were welcome to observe the entire refinement process, they were *only* involved in the discussion of those services for which they were invited to participate.
- Two primary care clinicians nominated by the American Academy of Family Physicians and the American Society of Internal Medicine.
- Four carrier medical directors.
- Four clinicians with practices in related specialties, who were expected to have knowledge of the services under review.

The panel discussed the work involved in each procedure under review in comparison to the work associated with other services on the fee schedule. We assembled a set of reference services and asked the panel members to compare the clinical aspects of the work of services they believed were incorrectly valued to one or more of the reference services. In compiling the set, we attempted to include—(1) services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The set contained approximately 300 services. Group members were encouraged to make comparisons to reference services. The intent of the panel process was to capture each participant's independent judgement based on the discussion and his or her clinical experience. Following each discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome this presumption, the inaccuracy of the interim RVUs had to be apparent to a broad range of physicians participating in the panel.

Ratings of work were analyzed for consistency among the groups represented on the panel. In general, we used statistical tests to determine whether there was enough agreement among the groups of the panel, and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the November 2000 final rule. We did not modify the RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the 1993 fee schedule. The statistical tests were described in detail in the November 25, 1992 final rule (57 FR 55938).

Our decision to convene a multispecialty refinement panel of physicians and to apply the statistical tests described above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties. Of the 3 codes reviewed by the multispecialty panel, all were the subject of requests for increased values. Of the 3 interim work RVUs that were reviewed, 2 were increased and 1 was unchanged.

We also received comments on RVUs that were interim for 2001, but which we did not submit to the panel for review for a variety of reasons. These comments and our decisions on those comments are discussed in further detail below.

Table 5 lists the interim and related codes reviewed during the refinement process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.
- Descriptor. This is an abbreviated version of the narrative description of the code.
- 2001 Work RVU. The work RVUs that appeared in the November 2000 rule are shown for each reviewed code.
- Requested Work RVU. This column identifies the work RVUs requested by commenters.
- 2002 Work RVU. This column contains the final RVUs for physician work.

TABLE 5.—REFINEMENT OF 2001 INTERIM WORK RELATIVE VALUE UNITS

[1] CPT code	Descriptor	2001 work RVU	Requested work RVU	2002 work RVU
19102	Bx breast percut w/image	2.00	2.73	2.00
19103	Bx breast percut w/device	2.37	5.55	3.70
22522	Percutaneous vertebroplasty, addl	3.00	4.31	4.31

[1] All CPT codes and descriptions copyright 2002 American Medical Association.

2. Interim 2001 Codes

Stenting Procedures—(CPT Codes 43256, 44370, 44379, 44383, 44397, 45345, 45387, and 45342)

We accepted the RUC recommended increase over the base code of 1.96 work RVUs. Commenters suggested that this increment should be increased to 2.59 work RVUs to reflect the work increase the RUC had recommended for CPT code 43219 (one of the codes used to arrive at this increase) as part of the 5-year review. Additionally, they also commented that the increment for the pre-dilation service should be from the dilation of gastric outlet in connection with an upper GI as opposed to the esophagoscopy code. Finally, commenters did not believe that these services should be subject to ''within family work neutrality adjustments'' (see *Final Decision* below) and instead believed that any increase in total RVUs should be addressed through the SGR or conversion factor. They felt that these stent placements are new technology and should not be viewed as code splitting/unbundling of services. They stated that stent placements have only been performed over the last 4–5 years and any work associated with them is

not reflected in current work values for endoscopic codes.

Final decision: ''Within family work neutrality adjustments'' are used for new or revised services that are not considered new technologies. To achieve work neutrality within families of services, we compare the new or revised work RVUs (weighted by projected frequency) to the old work RVUs (weighted by actual frequency) to ensure that additional RVUs have not been added based on fragmentation of existing codes. We agree with the commenter that these services are new technologies and thus should not be subject to within family work neutrality adjustments. With regard to the final work value for CPT code 43219 and the use of dilation and stent placement codes in assigning a work value to 43219, please see our discussion elsewhere in this rule.

Cryosurgical Ablation of the Prostate—CPT Code 55873

We agreed with the RUC recommended work RVU for CPT code 55873 as we felt that the comparison to CPT code 55801, Prostatectomy, perineal, subtotal, was appropriate to aid in setting the work RVU of CPT code 55873. One commenter did not agree that this comparison was appropriate. The commenter indicated that the RUC was being requested to review this service again at its February meeting.

Final decision: The RUC provided comments on interim valued CPT code 55873 that re-visited the appropriate comparison service. Based upon comments received, the final work RVUs for CPT code 55873 will be increased to 19.47.

Percutaneous Vertebroplasty—CPT Code 22522

We disagreed with the RUC-recommended work RVUs of 4.31 for this service. CPT code 22522 is an add-on code that should have no associated pre- or postservice work. We removed the pre- and postservice work from the weighted average of CPT codes 22520 and 22521, which are the base services with which add-on CPT code 22522 should be billed in conjunction, and recalculated the value. Thus, we assigned interim work RVUs of 3.00 for CPT code 22522. Several commenters disagreed and do not believe that our methodology has appropriately valued this add-on service. Commenters felt we should sum the work RVUs of CPT codes 22520 and 22521 and then take 50 percent of this value. They believe that this is how we historically have calculated work RVUs for add-on services. Based on these comments, we referred this code to a multispecialty refinement panel for review.

Final decision: As a result of the statistical analysis of the refinement panel ratings, the final work RVUs are 4.31 for CPT code 22522.

Fetal Biophysical Stress Testing—CPT Codes 76818 and 76819

Although we agreed with the relativity presented by the RUC, we reduced the RVUs for these aforementioned services due to within family work neutrality adjustments. As previously discussed, within family work neutrality adjustments are used to ensure that additional relative values are not added based on fragmentation of existing codes. One specialty organization felt that we inappropriately determined that the work associated with the original CPT code 76818 (CPT code 76819 was added for January 1, 2001), included the average work of both with and without non-stress test. It believes that the survey data presented to the RUC suggest that this assumption is invalid and that the inappropriate within family neutralization of these services creates a rank-order anomaly in this family of codes.

The survey data indicated that CPT code 76818 required more time and greater mental effort than CPT code 76805 (Complete OB ultrasound), which has 0.99 work RVUs, since the ultrasound portion of CPT code 76818, while less extensive, is typically performed in a high-risk situation. In addition, CPT code 76818 also includes CPT code 59025 (Fetal non-stress test) with work RVUs of 0.53. The specialty organization also reported that CPT code 76819 requires more work than CPT code 76815 (Limited obstetric ultrasound) with work RVUs of 0.65. The assignment of 0.86 RVUs to CPT code 76818 and 0.63 RVUs to 76819 creates a rank-order anomaly with this family of obstetric ultrasound procedures.

Final Decision: We agree with the commenter that the within family neutrality adjustment we made for 2001 was not appropriate and created a rank-order anomaly within this family of services. We will remove the neutrality adjustments for January 1, 2002.

Cognitive Skills and Sensory Integrative Techniques—CPT Codes 97532 and 97533

We did not agree with the HCPAC recommendation for CPT codes 97532 and 97533 (work RVUs of 0.51 and 0.48, respectively). These two new services were created to replace deleted CPT code 97770. We believed that the work associated with these new services is analogous to deleted CPT code 97770 and therefore, we assigned work RVUs of 0.44 (the value assigned to the deleted code) to these new replacement codes. Commenters felt that assignment of this work value was arbitrary on our part, particularly since the HCPAC information had been based on information from a survey completed by the practitioners who provide these services.

Final Decision: We disagree with the commenters and are finalizing the interim work values. This is an example of replacing one CPT code with two new CPT codes that describe identical work. Because there is no new technology involved, we will finalize the interim work RVUs.

Wound Care CPT Codes

Absent a HCPAC recommendation for either of the aforementioned CPT codes, we valued the work of CPT code 97601 as 0.50 RVUs, the same as deleted service G0169 that described the work in the new code. We considered CPT code 97602 to be bundled into CPT code 97601 and therefore did not establish work RVUs for this service. Commenters believed that we inappropriately bundled CPT code 97602 into 97601 since they represent distinct services. The commenters requested that we reconsider bundling CPT code 97602.

Final Decision: We have re-examined our determination but have not changed our decision. CPT code 97602 describes services that typically involve placement of a wound covering, for example, wet-to-dry gauze or enzyme-treated dressing. It also includes nonspecific removal of devitalized tissue that is an inherent part of changing a dressing. This service is already included in the work and practice expenses of CPT code 97601. In the typical service described by 97601, the patient has a dressing placed over the wound. We would add that the services described by 97602 are also included in the work and practice expenses of the whirlpool code, CPT 97022. For this reason, we consider this a bundled service that is not paid separately.

Percutaneous Breast Biopsy—CPT Codes 19102 and 19103

We agreed with the RUC recommended work RVUs of CPT codes 19102 (RVU = 2.00) and 19103 (RVU = 2.37). Commenters believed that the work RVUs assigned to these codes were inappropriately low and did not accurately reflect the time and intensity of the work involved. Commenters supplied information to support their request for increasing the work RVUs for

these services. Based on these comments, we referred this code to a multispecialty refinement panel for review.

Final decision: As a result of the statistical analysis of the multispecialty refinement panel ratings, the final work RVUs for CPT code 19102 are 2.00, and the final work RVUs for CPT code 19103 are 3.70.

Magnetic Resonance Imaging Procedures—CPT codes 70540, 70542, 70543, 71550, 71551, 71552, 72195, 72196, 72197, 73218, 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723, 74181, 74182, and 74183

We received a RUC recommendation for only 3 of these codes (*70540, 70542, 70543*) for January 1, 2001. However, this recommendation did not reflect the required within family work neutrality adjustment. The work RVUs of 0.98, 1.17, and 1.56 were assigned to these services to ensure that there would not be additional work RVUs introduced into the system. We did not receive work recommendations or utilization data for any of the other new MRI codes and assigned work RVUs for these other codes based on the methodology outlined in the November 2000 final rule.

Commenters expressed concern about the within family work neutrality adjustment applied to the RUC-recommended work RVUs, and the methodology that was used to establish work values for the other MRI procedures. Commenters requested that we re-evaluate the within family work neutrality adjustment based upon updated information supplied in their respective comments.

Final decision: We are accepting the work values for these services which were submitted by the RUC in its comment on the interim work values we assigned in last year's final rule. We note that these work values are virtually identical to the work values that we assigned as interim last year. Based upon comments received, we have re-evaluated the utilization crosswalks upon which our within family work neutrality adjustments were based.

Since 2001 is the first year for which actual data is available for these services, we used available data (first two quarters of 2001) to capture the actual utilization of these new services. This utilization was then subjected to a standard analysis of reporting trends to estimate the completion percentage of 2001 utilization data. The available utilization was then ''aged'' to represent one full year of data for 2001. After determining the utilization for 2001, we applied this revised within family work neutrality adjustment across the entire family of MRI procedures rather than applying this adjustment to subsets. We are finalizing these within family work neutral values and note that the re-calculation of this neutrality adjustment results in increases to the work RVUs of the MRI services referenced above.

Computed Tomographic Angiography (CTA)—CPT Codes 70496, 70498, 71275, 72191, 73206, 73706, 74175 and 75635

We agreed with the RUC recommendation of 1.75 for CPT codes 70496 and 70498 for January 1, 2001. However, the RUC did not submit work recommendations for the other CTA codes. We assigned work RVUs for these other codes based on the methodology outlined in the November 2000 rule. Commenters disagreed with the interim values we had proposed for CTA codes and provided additional information for valuing these services. The commenter felt that our decisions created rank-order anomalies between anatomic sites.

Final decision: We are accepting the work values for these services which were submitted by the RUC in its comment on the interim work values we assigned in last year's final rule. We will implement them as final values for 2002.

Practice Expense Refinements of 2001 Interim and Revised RVUs

Percutaneous Breast Biopsy—CPT Codes 19102 and 19103

Comment: A specialty organization representing breast surgeons submitted its suggested direct cost inputs for these two services and had several comments on their practice expenses. The commenter indicated that the price in the database for the biopsy driver was too low, that the clinical staff type should be a registered nurse rather than a technician and that there should be pre- and postservice clinical staff time when the procedure is performed in the facility setting. In addition, the commenter questioned whether the 50 percent utilization rate used to price equipment was realistic for new technology and recommended that device-specific utilization rates be determined. The society also questioned the lack of direct cost inputs for equipment and supplies for CPT 76095, the associated procedure for image guidance. A manufacturer commented that the equipment inputs for CPT 19102 were erroneously dropped from the CPEP database.

Response: We had accepted the RUC recommendations on these two services, making only the following technical changes to the supplies and equipment: we did not include the cost of the crash cart, because we consider this an indirect expense, nor the cost of the biopsy gun handle, because this was less than the $500 required for an item to be on the equipment list. We also did not include separately billable fluids, the formalin that would be supplied by the lab, or the biohazard bag and skin marking pen that could be used for more than one procedure.

If the specialty that was involved in the presentation of these codes to the RUC now believes that the direct inputs do not adequately represent the costs of performing these services, one option would be to have these codes refined by the PEAC. In the meantime, we are prepared to make certain changes to the CPEP data in response to the recommendations made by the commenters. We will add the power table and surgical lamp to both codes and will increase the price associated with the biopsy device driver, subject to verification when we undertake our repricing of the CPEP equipment inputs. Because the specialties presenting the codes to the RUC, and the RUC itself, recommended using radiologic staff for these services, we will not change the staff type to registered nurse at this time. However, we will substitute the higher-paid mammography technologist, which we have just added to our staff type list, for the current x-ray technician staff type.

We have in the past solicited information from the specialties regarding equipment-specific utilization rates, but we have never received sufficient information to propose any changes in our policy. Additionally, for most services, changing the utilization rate would have very little effect.

The commenter is correct that the associated procedure for image guidance, CPT 76095, currently does not have CPEP inputs assigned to the non-facility setting. However, at this time, it is priced as a part of the ''zero work'' pool, and the CPEP inputs are not used to calculate the practice expense RVUs for this service. We would hope that this code could be refined in the near future and given the appropriate inputs for the office setting.

CPT Codes 34812, 34820, 34830, 34831 and 34832 for Repair of Aortic Aneurysm

Comment: A specialty organization representing vascular surgery stated that CPT codes 34812 and 34820 should have clinical staff preservice time added and that CPT codes 34830, 34831 and

34832 were assigned inappropriately low postservice clinical staff times.

Response: We accepted the RUC recommendations for all of these services. There was no preservice time included in the RUC recommendation for CPT codes 34812 and 34820. In addition, we have assigned 99 minutes of clinical staff postservice time to CPT codes 34830, 34831 and 34832, as recommended by the RUC. These codes can be refined by the PEAC which now has a standard package for 90-day global pre- and postservice times for clinical staff and is also discussing the coordination of care clinical staff times for 0-day global services.

We received the following comments on HCPCS codes established in the November 1, 2000 final rule.

• G0169 Removal of Devitalized tissue, without use of anesthesia.

Comment: The American Podiatric Medical Association recognized that, effective January 1, 2001, this code was eliminated and we have adopted CPT code 97601, which is sufficiently similar to the services described by G0169. However, it requested we address a policy issue related to the discussion of this service. In the November 2, 1999 **Federal Register** (64 FR 59426), we stated that G0169 was created because CPT codes 11040 through 11044 for debridement were created to describe ''complex surgical services requiring the use of general anesthesia.'' APMA indicates that there had never been a policy requiring the use of *any* anesthesia, much less general anesthesia, when performing surgical debridement that is reported with CPT codes 11040 through 11044. However, as a result of the statement in the November 2 **Federal Register**, some carriers developed policies denying payment for these codes if anesthesia was not used. The APMA urged us to clarify that anesthesia, whether general or local, is not required when billing CPT codes 11040 through 11044.

Response: We acknowledge that the use of ''general anesthesia'' in the preamble to the November 2, 1999 rule was an error, and we believe all our contractors are aware of our misstatement. As the commenter stated, the code G0169 has been deleted and replaced by CPT code 97601, *Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (e.g., high pressure waterjet, shape selective debridement with scissors, scalpel, and tweezers) including topical application(s), wound assessment, and instruction(s) for ongoing care, one session.* We expect that our contractors will develop policies to distinguish this service from the debridement codes, 11040 through 11044. We anticipate that they may consider a variety of factors, including the extent of the debridement and the amount of medical skill required to perform the service, and not simply whether a local anesthetic was used in the procedure.

Comment: The American College of Surgeons urged us to issue instructions to carriers specifying that the use of CPT code 97061 is limited to physical therapists and other non-physician practitioners and that the debridement of wounds by surgeons is properly reported with a code from the CPT debridement codes 11040–11044.

Response: As we stated in the response to the previous comment, we believe that our contractors are likely to make this distinction in their local policies. If we determine that relying on local carrier policies is unsatisfactory, then we will consider whether national guidance is needed.

• *G0181 and G0182, Care plan Oversight.*

Comment: A few organizations expressed disappointment that we finalized our proposal to establish two new G codes for care plan oversight services, rather than continue to recognize the CPT codes related to these services.

Response: The CPT codes for care plan oversight were modified so that they included services that extend beyond the limits of our current payment policy. As a result, we will continue to use the G-codes that are consistent with our payment policies.

• *G0180 and G0179 Certification and Recertification of Medicare Covered Home Health Services.*

Comment: Several specialty organizations expressed appreciation for our willingness to recognize and compensate physicians for these services and supported our decision to pursue this coding and reimbursement issue through the CPT and RUC processes. The American College of Surgeons expressed concern that claims submitted by surgeons for physician certification or recertification would be denied inappropriately due to longstanding rules that preclude payment for services that are provided during the global period.

Response: As was stated in the November 1, 2000 final rule (66 FR 65408), surgeons performing these services could be paid for G0179 and G0180 during the global period. We have heard no specific complaints that this policy has not been implemented appropriately.

G Codes Related to Swallowing Function

Comment: The American College of Surgeons objected to the creation of these G codes and requested that we discontinue their use and work with the otolaryngologists to submit a coding request on these services to the CPT Editorial Panel. The American Academy of Otolaryngology—Head and Neck Surgery, Inc. (AAO–HNS) also expressed concern about creation of these codes. It felt that our description of the codes was incomplete and inaccurate.

In the November 1, 2000 final rule we proposed 4 new G codes and stated that these would replace the more general CPT code 92525, *Evaluation of swallowing and oral function for feeding.* AAO–HNS believes that this incorrectly implies that the single code 92525 includes 4 unique services and, therefore, we have significantly understated the work and practice expenses required for these procedures.

For *G0193, Endoscopy study of swallowing function, and GO194 Sensory testing during endoscoping study of swallowing,* we stated that coverage of these services remains at the discretion of the carrier and that they would be carrier priced. AAO–HNS expressed concern that carriers might misinterpret this statement to mean the codes should not be covered and, if covered, the payment might be inappropriately low. AAO–HNS requested we clarify that these services should be covered and recommended that pricing for GO193 should equal to the sum of the RVUs for CPT code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic,* and CPT code 92525.

AAO–HNS also did not agree with our decision to treat G0194 as an ''add-on'' code as this group felt this would create confusion. Rather, AAO–HNS suggested that GO194 be treated as a stand-alone code with RVUs equal to CPT codes 31575, 92525 and 92520 (*Laryngeal function studies*).

In addition, AAO–HNS was concerned about our statement that CPT code 31575 and CPT code 31579 (*Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy*) should not be used for evaluations of swallowing and urged that we clarify that these codes could still be used to report flexible fiberoptic laryngosopies for patients with swallowing problems.

Response: These G codes related to swallowing function were created because of the ambiguity of the CPT code, 92525. The CPT editorial panel will be reviewing codes designed to substitute for the G-codes created. The specialty advisors, including AAO–

HNS, will have the opportunity to comment on these proposals and to create codes that they believe will describe the services more accurately. If the CPT editorial panel adopts these revised codes, they could be in the 2003 CPT book.

Comment: The American Occupational Therapy Association stated that in the specific discussion of code GO195, and by implication the related codes, we stated these services are performed typically by a speech and language pathologist. While AOTA does not disagree with this characterization, it requested that we clarify that other professionals, specifically occupational therapists, also may be trained in these procedures. It noted that in some areas of the country occupational therapists typically perform swallowing evaluations, particularly in conjunction with feeding and eating deficits.

Response: These G codes did not specify which professionals could perform these services. The description of the new G codes only stated that these services would be most commonly performed by speech and language pathologists. Our contractors, who have the capacity to be responsive to local differences in practice patterns, will be aware of whether occupational therapists have the qualifications to perform these evaluations and will make the decisions about whether the service performed matches the services described by the code.

Comment: The American College of Radiology requested clarification on the specialties we anticipate using G0196; they asked if this G code would be used by the speech pathologist while the radiologist would use CPT code 74230. ACR expressed concern that provision of such a G code would promote performance of fluoroscopy by non-trained individuals.

Response: We do not believe that the development of these G codes should lead to non-trained individuals performing fluoroscopy. Prior to the development of the G codes, we were asked by speech and language pathologists if they could bill 74230 to describe the work they did in conjunction with a fluoroscopic or video evaluation of swallowing. We did not think that the speech and language pathologists should bill the code 74230 and created this G code to describe the portion of the examination that they typically performed.

We were also asked whether the services of a speech and language pathologist should have remained bundled into the technical portion of the 74230 examination, because this may have been the method of billing these services prior to the development of the G code. Because this new G code separates the services of the speech and language pathologists in this examination, we may need to clarify which services are included in the technical portion of 74230. None of these concerns would lead a non-skilled practitioner to perform either of these services.

G Codes Related to Speech Generating Devices and Voice Prostheses G0197–G0201

Comment: AAO–HNS expressed concern about the establishment of G codes related to speech generating devices and voice prostheses. It continues to believe that the creation of codes used to describe services that are already described in CPT makes compliance with Medicare policy difficult and confusing.

Response: The current CPT codes, 92597 and 92598, identify two distinct services—evaluation or modification of voice prosthetics and augmentative or alternative communicative devices. Since different types of patients require either voice prosthetics (for example, an artificial larynx) or augmentative or alternative communicative devices, we believe that separating these two services through the use of G-codes actually should make compliance with Medicare policies easier, since the services being delivered are more accurately described.

Revisions to Malpractice RVUs for New and Revised CPT Codes for 2001

Malpractice RVUs are calculated using the methodology described in detail at Addendum G of our November 1, 2000 final rule (65 FR 65589). Because of the timing of the release of new and revised CPT codes each year, the malpractice RVUs for the first year of these codes are extrapolated from existing similar codes, based on the advice of our medical consultants, and are considered interim subject to public comment and revision. The following year these codes are given values based on our malpractice RVU methodology and a review of comments received.

The malpractice RVUs for 2001 new and revised codes published in Addendum B of the November 1, 2000 final rule were thus extrapolated from (RVUs for existing similar codes). The malpractice RVUs for these codes in this year's Addendum B were calculated by our consultant, KPMG, using the same methodology used for all other codes. Likewise, the malpractice RVUs for new and revised 2002 codes are being extrapolated from existing similar codes and will be calculated using the malpractice RVU methodology next year.

Comment: One commenter stated that malpractice premiums are rapidly increasing all over the country and that we should ensure that the physician fee schedule reflect these increases.

Response: We agree that changes in malpractice premiums should, to the extent possible, be reflected in the physician fee schedule. The most recent malpractice data available were used in constructing the 2001 malpractice RVUs and the revised 2001 GPCIs. In addition, the relative weights of the component cost shares (work, practice expense, malpractice) in the physician fee schedule and in the MEI are periodically adjusted when the most recent AMA SMS data indicate significant shifts among physician practice cost components. However, because of the time needed to collect the data and propose changes through the rulemaking process, there is a time lag in making these changes.

Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2002 (Includes Table 6, AMA RUC and HCPAC Work RVU Recommendations and CMS Decisions for New and Revised 2002 CPT Codes)

One aspect of establishing RVUs for 2002 was related to the assignment of interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice in the 1993 fee schedule (57 FR 55983), and in section III.B. of our November 22, 1996 final rule (61 FR 59505–59506), we established a process, based on recommendations received from the AMA's RUC, for establishing interim work RVUs for new and revised codes.

This year we received RUC work RVU recommendations for approximately 314 new and revised CPT codes. Our staff and medical officers reviewed the RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had been previously established, or to both of these criteria. We also considered the relationships among the new and revised codes for which we received RUC recommendations. We agreed with the majority of these relationships reflected in the RUC values. In some instances, when we agreed with the relationships, we revised the work RVUs to achieve work neutrality within families of codes, that is, the work RVUs have been adjusted so that the sum of the new or revised work RVUs

(weighted by projected frequency of use) for a family will be the same as the sum of the current work RVUs (weighted by projected frequency of use for that family of codes). For approximately 93 percent of the RUC recommendations, proposed work RVUs were accepted, and for approximately 7 percent, we disagreed with the RUC recommendation. In a majority of instances, we agreed with the relativity proposed by the RUC, but needed to decrease work RVUs to retain budget neutrality.

There were also 10 CPT codes for which we did not receive a RUC recommendation. After a review of these CPT codes by our staff and medical officers, we established interim work RVUs for the majority of these services. For those services for which we could not arrive at interim work RVUs, we have assigned a carrier-priced status until such time as the RUC provides work RVU recommendations.

We received 18 recommendations from the Health Care Professionals Advisory Committee (HCPAC). We accepted 12, or 67 percent, of the HCPAC recommendations.

Table 6, AMA RUC and HCPAC Work RVU Recommendations and CMS Decisions for New and Revised 2002 CPT Codes, lists the new or revised CPT codes, and their associated work RVUs, that will be interim in 2002. This table includes the following information:

- A ''#'' identifies a new code for 2002.
- CPT code. This is the CPT code for a service.
- Modifier. A ''26'' in this column indicates that the work RVUs are for the professional component of the code.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the work RVUs recommended by the RUC.
- HCPAC recommendations. This column identifies the work RVUs recommended by the HCPAC.
- CMS decision. This column indicates whether we agreed with the RUC recommendation (''agree'') or we disagreed with the RUC recommendation (''disagree''). Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table. An ''(a)'' indicates that no RUC recommendation was provided. A discussion follows the table.
- 2002 Work RVUs. This column establishes the 2002 work RVUs for physician work.

TABLE 6.—AMA RUC AND HCPAC WORK RVU RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2002 CPT CODES

*CPT CODE	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2002 work RVU
10021 #	26	FNA W/O IMAGE	1.27		Agree	1.27
10022 #	26	FNA W/IMAGE	1.27		Agree	1.27
11755		BIOPSY, NAIL UNIT	1.31		Agree	1.31
11981 #		INSERT DRUG IMPLANT DEVICE	1.48		Agree	1.48
11982 #		REMOVE DRUG IMPLANT DEVICE	1.78		Agree	1.78
11983 #		REMOVE/INSERT DRUG IMPLANT	3.30		Agree	3.30
17000		DESTROY BENIGN/PREMAL LESION	0.60		Agree	0.60
17003		DESTROY LESIONS, 2–14	0.15		Agree	0.15
17004		DESTROY LESIONS, 15 OR MORE	2.79		Agree	2.79
17110		DESTRUCT LESION, 1–14	0.65		Agree	0.65
17111		DESTRUCT LESION, 15 OR MORE	0.92		Agree	0.92
17260		DESTRUCTION OF SKIN LESIONS	0.91		Agree	0.91
17261		DESTRUCTION OF SKIN LESIONS	1.71		Agree	1.71
17262		DESTRUCTION OF SKIN LESIONS	1.58		Agree	1.58
17263		DESTRUCTION OF SKIN LESIONS	1.79		Agree	1.79
17264		DESTRUCTION OF SKIN LESIONS	1.94		Agree	1.94
17266		DESTRUCTION OF SKIN LESIONS	2.34		Agree	2.34
17270		DESTRUCTION OF SKIN LESIONS	1.32		Agree	1.32
17271		DESTRUCTION OF SKIN LESIONS	1.49		Agree	1.49
17272		DESTRUCTION OF SKIN LESIONS	1.77		Agree	1.77
17273		DESTRUCTION OF SKIN LESIONS	2.05		Agree	2.05
17274		DESTRUCTION OF SKIN LESIONS	2.59		Agree	2.59
17276		DESTRUCTION OF SKIN LESIONS	3.20		Agree	3.20
17280		DESTRUCTION OF SKIN LESIONS	1.17		Agree	1.17
17281		DESTRUCTION OF SKIN LESIONS	1.72		Agree	1.72
17282		DESTRUCTION OF SKIN LESIONS	2.04		Agree	2.04
17283		DESTRUCTION OF SKIN LESIONS	2.64		Agree	2.64
17284		DESTRUCTION OF SKIN LESIONS	3.21		Agree	3.21
17286		DESTRUCTION OF SKIN LESIONS	4.44		Agree	4.44
20225		BONE BIOPSY, TROCAR/NEEDLE	1.87		Agree	1.87
20526 #		THER INJECTION, CARPAL TUNNEL	0.86		Agree	0.86
20550		INJECT TENDON/LIGAMENT/CYST	0.86		Agree	0.86
20551 #		INJECT TENDON ORIGIN/INSERT	0.86		Agree	0.86
20552 #		INJECT TRIGGER POINT, 1 OR 2	0.86		Agree	0.86
20553 #		INJECT TRIGGER POINTS, 3	0.86		Agree	0.86
23000		REMOVAL OF CALCIUM DEPOSITS	4.36		Agree	4.36
23350		INJECTION FOR SHOULDER X-RAY	1.00		Agree	1.00
24075		REMOVE ARM/ELBOW LESION	3.92		Agree	3.92
24076		REMOVE ARM/ELBOW LESION	6.30		Agree	6.30
24300 #		MANIPULATE ELBOW W/ANESTH	3.75		Agree	3.75
24332 #		TENOLYSIS, TRICEPS	7.45		Agree	7.45
24343 #		REPR ELBOW LAT LIGMNT W/TISS	8.65		Agree	8.65
24344 #		RECONSTRUCT ELBOW LAT LIGMNT	14.00		Agree	14.00

TABLE 6.—AMA RUC AND HCPAC WORK RVU RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2002 CPT CODES—Continued

*CPT CODE	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2002 work RVU
24345 #		REPR ELBW MED LIGMNT W/TISS	8.65		Agree	8.65
24346 #		RECONSTRUCT ELBOW MED LIGMNT	14.00		Agree	14.00
25001 #		INCISE FLEXOR CARPI RADIALIS	3.38		Agree	3.38
25020		DECOMPRESS FOREARM 1 SPACE	5.92		Agree	5.92
25023		DECOMPRESS FOREARM 1 SPACE	12.96		Agree	12.96
25024 #		DECOMPRESS FOREARM 2 SPACES	9.50		Agree	9.50
25025 #		DECOMPRESS FORAM 2 SPACES	16.54		Agree	16.54
25075		REMOVE FOREARM LESION SUBCUT	3.74		Agree	3.74
25076		REMOVE FOREARM LESION DEEP	4.92		Agree	4.92
25259 #		MANIPULATE WRIST W/ANESTHES	3.75		Agree	3.75
25274		REPAIR FOREARM TENDON/MUSCLE	8.75		Agree	8.75
25275 #		REPAIR FOREARM TENDON SHEATH	8.50		Agree	8.50
25394 #		REPAIR CARPAL BONE, SHORTEN	10.40		Agree	10.40
25405		REPAIR/GRAFT RADIUS OR ULNA	14.38		Agree	14.38
25420		REPAIR/GRAFT RADIUS & ULNA	16.33		Agree	16.33
25430 #		VASC GRAFT INTO CARPAL BONE	9.25		Agree	9.25
25431 #		REPAIR NONUNION CARPAL BONE	10.44		Agree	10.44
25440		REPAIR/GRAFT WRIST BONE	10.44		Agree	10.44
25520		TREAT FRACTURE OR RADIUS	6.26		Agree	6.26
25526		TREAT FRACTURE OF RADIUS	12.98		Agree	12.98
25645		TREAT WRITST BONE FRACTURE	7.25		Agree	7.25
25651 #		PIN ULNAR STYLOID FRACTURE	5.36		Agree	5.36
25652 #		TREAT FRACTURE ULNAR STYLOID	7.60		Agree	7.60
25671 #		PIN RADIOULNAR DISLOCATION	6.00		Agree	6.00
26115		REMOVE HAND LESION SUBCUT	3.86		Agree	3.86
26116		REMOVE HAND LESION, DEEP	5.53		Agree	5.53
26160		REMOVE TENDON SHEATH LESION	3.15		Agree	3.15
26250		EXTENSIVE HAND SURGERY	7.55		Agree	7.55
26255		EXTENSIVE HAND SURGERY	12.43		Agree	12.43
26340 #		MANIPULATE FINGER W/ANESTH	2.50		Agree	2.50
26350		REPAIR FINGER/HAND TENDON	5.99		Agree	5.99
26352		REPAIR/GRAFT HAND TENDON	7.68		Agree	7.68
26356		REPAIR FINGER/HAND TENDON	8.07		Agree	8.07
26357		REPAIR FINGER/HAND TENDON	8.58		Agree	8.58
26358		REPAIR/GRAFT HAND TENDON	9.14		Agree	9.14
26390		REVISE HAND/FINGER TENDON	9.19		Agree	9.19
26392		REPAIR/GRAFT HAND TENDON	10.26		Agree	10.26
26415		EXCISION, HAND/FINGER TENDON	8.34		Agree	8.34
26416		GRAFT HAND OR FINGER TENDON	9.37		Agree	9.37
26426		REPAIR FINGER/HAND TENDON	6.15		Agree	6.15
26428		REPAIR/GRAFT FINGER TENDON	7.21		Agree	7.21
26445		RELEASE HAND/FINGER TENDON	4.31		Agree	4.31
26510		THUMB TENDON TRANSFER	5.43		Agree	5.43
26587		RECONSTRUCT EXTRA FINGER	14.05		Agree	14.05
26590		REPAIR FINGER DEFORMITY	17.96		Agree	17.96
26607		TREAT METACARPAL FRACTURE	5.36		Agree	5.36
26608		TREAT METACARPAL FRACTURE	5.36		Agree	5.36
26670		TREAT HAND DISLOCATION	3.69		Agree	3.69
26675		TREAT HAND DISLOCATION	4.54		Agree	4.54
26676		PINE HAND DISLOCATION	5.52		Agree	5.52
26685		TREAT HAND DISLOCATION	6.98		Agree	6.98
26843		FUSION OF HAND JOINT	7.61		Agree	7.61
26844		FUSION/GRAFT OF HAND JOINT	8.73		Agree	8.73
27096		INJECT SACROILIAC JOINT	1.40		Agree	1.40
28299		CORRECTION OF BUNION	10.58		Agree	10.58
29086 #		APPLY FINGER CAST	0.62		Agree	0.62
29805 #		SHOULDER ARTHROSCOPY, DX	5.89		Agree	5.89
29806 #		SHOULDER ARTHROSCOPY/SURGERY.	14.37		Agree	14.37
29807 #		SHOULDER ARTHROSCOPY/SURGERY.	13.90		Agree	13.90
29819		SHOULDER ARTHROSCOPY/SURGERY.	7.62		Agree	7.62
29820		SHOULDER ARTHROSCOPY/SURGERY.	7.07		Agree	7.07
29821		SHOULDER ARTHROSCOPY/SURGERY.	7.72		Agree	7.72
29822		SHOULDER ARTHROSCOPY/SURGERY.	7.43		Agree	7.43

TABLE 6.—AMA RUC AND HCPAC WORK RVU RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2002 CPT CODES—Continued

*CPT CODE	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2002 work RVU
29823		SHOULDER ARTHROSCOPY/SURGERY.	8.17		Agree	8.17
29824 #		SHOULDER ARTHROSCOPY/SURGERY.	8.25		Agree	8.25
29900 #		MCP JOINT ARTHROSCOPY, DX	5.42		Agree	5.42
29901 #		MCP JOINT ARTHROSCOPY, SURG	6.13		Agree	6.13
29902 #		MCP JOINT ARTHROSCOPY, SURG	6.70		Agree	6.70
30117		REMOVAL OF INTRANASAL LESION	3.16		Agree	3.16
30118		REMOVAL OF INTRANASAL LESION	9.69		Agree	9.69
31641		BRONCHOSCOPY, TREAT BLOCKAGE	5.03		Agree	5.03
32650		THORACOSCOPY, SURGICAL	10.75		Agree	10.75
33967 #		INSERT IA PERCUT DEVICE	4.85		Agree	4.85
33975		IMPLANT VENTRICULAR DEVICE	21.00		Agree	21.00
33976		IMPLANT VENTRICULAR DEVICE	23.00		Agree	23.00
33977		REMOVE VENTRICULAR DEVICE	19.29		Agree	19.29
33978		REMOVE VENTRICULAR DEVICE	21.73		Agree	21.73
33979 #		INSERT INTRACORPOREAL DEVICE	carrier		Agree	carrier
33980 #		REMOVE INTRACORPOREAL DEVICE	carrier		Agree	carrier
35646		ARTERY BYPASS GRAFT	31.00		Agree	31.00
35647 #		ARTERY BYPASS GRAFT	28.00		Agree	28.00
35685		BYPASS GRAFT PATENCY/PATCH	4.05		Agree	4.05
35686 #		BYPASS GRAFT/AV FIST PATENCY	3.35		Agree	3.35
36002 #		PSEUDOANEURYSM INJECTION TRT	1.96		Agree	1.96
36005		INJECTION EXT VENOGRAPHY	0.95		Agree	0.95
36400		DRAWING BLOOD	0.38		Agree	0.38
36819		AV FUSION/UPPR ARM VEIN	14.00		Agree	14.00
36820 #		AV FUSION/FOREARM VEIN	14.00		Agree	14.00
36823		INSERTION OF CANNULA(S)	21.00		Agree	21.00
38220 #		BONE MARROW ASPIRATION	1.08		Agree	1.08
38221 #		BONE MARROW BIOPSY	1.37		Agree	1.37
43200		ESOPHAGUS ENDOSCOPY	1.59		Agree	1.59
43227		ESOPH ENDOSCOPY, REPAIR	3.60		Agree	3.60
43245		OPERATIVE UPPER GI ENDOSCOPY	3.39		Agree	3.39
43310		REPAIR OF ESOPHAGUS	27.47		Agree	27.47
43312		REPAIR ESOPHAGUS AND FISTULA	30.50		Agree	30.50
43313 #		ESOPHAGOPLASTY CONGENITAL	45.28		Agree	45.28
43314 #		TRACHEO-ESOPHAGOPLASTY CONG	50.27		Agree	50.27
44120		REMOVAL OF SMALL INTESTINE	17.00		Agree	17.00
44121		REMOVAL OF SMALL INTESTINE	4.45		Agree	4.45
44126 #		ENTERECTOMY W/TAPER, CONG	35.50		Agree	35.50
44127 #		ENTERECTOMY W/O TAPER, CONG	41.00		Agree	41.00
44128 #		ENTERECTOMY CONG, ADD-ON	4.45		Agree	4.45
44140		PARTIAL REMOVAL OF COLON	18.35		Agree	18.35
44160		REMOVAL OF COLON	18.62		Agree	18.62
44202		LAP RESPECT S/INTESTINE SINGL	22.04		Agree	22.04
44203 #		LAP RESECT S/INTESTINE, ADDL	4.45		Agree	4.45
44204 #		LAPARO PARTIAL COLECTOMY	22.00		Disagree	25.08
44205 #		LAP COLECTOMY PART W/ILEUM	19.50		Disagree	22.23
44366		SMALL BOWEL ENDOSCOPY	4.41		Agree	4.41
44378		SMALL BOWEL ENDOSCOPY	5.26		Agree	5.26
44391		COLONOSCOPY FOR BLEEDING	3.82		Agree	3.82
45136 #		EXCISE ILEOANAL RESERVOIR	27.30		Agree	27.30
45190		DESTRUCTION, RECTAL TUMOR	8.28		Agree	8.28
45303		PROCTOSIGMOIDOSCOPY DILATE	0.44		Agree	0.44
45317		PROTOSIGMOIDOSCOPY BLEED	1.50		Agree	1.50
45334		SIGMOIDOSCOPY FOR BLEEDING	2.73		Agree	2.73
45382		COLONOSCOPY/CONTROL BLEEDING	5.69		Agree	5.69
46020 #		PLACEMENT OF SETON	2.90		Agree	2.90
46604		ANOSCOPY AND DILATION	1.31		Agree	1.31
46614		ANOSCOPY/CONTROL BLEEDING	2.01		Agree	2.01
46924		DESTRUCTION, ANAL LESION(S)	2.76		Agree	2.76
47370 #		LAPARO ABLATE LIVER TUMORE RF	(a)		(a)	18.00
47371 #		LAPARO ABLATE LIVER CRYOSUG	(a)		(a)	16.94
47380 #		OPEN ABLATE LIVER TUMOR RF	(a)		(a)	21.25
47381 #		OPEN ABLATE LIVER TUMOR CRYO	(a)		(a)	21.00
47382 #		PERCUT ABLATE LIVER RF	(a)		(a)	12.00
48100		BIOPSY OF PANCREAS, OPEN	11.08		Agree	11.08
49424		ASSESS CYST, CONTRAST INJECT	0.76		Agree	0.76
49491 #		REPAIRING HERN PREMIE REDUC	11.13		Agree	11.13

TABLE 6.—AMA RUC AND HCPAC WORK RVU RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2002 CPT CODES—Continued

*CPT CODE	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2002 work RVU
49492 #		RPR ING HERN PREMIE, BLOCKED	14.03		Agree	14.03
49495		RPR ING HERNIA BABY, REDUC	5.89		Agree	5.89
49496		RPR ING HERNIA BABY, BLOCKED	8.79		Agree	8.79
50220		REMOVE KIDNEY, OPEN	17.15		Agree	17.15
50225		REMOVAL KIDNEY OPEN, COMPLEX	20.23		Agree	20.23
50230		REMOVAL KIDNEY OPEN, RADICAL	22.07		Agree	22.07
51596		REMOVE BLADDER/CREATE POUCH	39.52		Agree	39.52
52001 #		CYSTOSCOPY, REMOVAL OF CLOTS	5.45		Disagree	2.37
52347 #		CYSTOSCOPY, RESECT DUCTS	5.28		Agree	5.28
52510		DILATIONPROSTATIC URETHRA	6.72		Agree	6.72
53431 #		RECONSTRUCT URETHRA/BLADDER	19.89		Agree	19.89
53444 #		INSERT TANDEM CUFF	13.40		Agree	13.40
53445		INSERT URO./VES NCK SPHINCTER	14.06		Agree	14.06
53446 #		REMOVE URO SPHINCTER	10.23		Agree	10.23
53447		REMOVE/REPLACE UR SPHINCTER	13.49		Agree	13.49
53448 #		REMOVE/REPLC UR SPHINCTR COMP	21.15		Agree	21.15
53449		REPAIR URO SPHINCTER	9.70		Agree	9.70
53853 #		PROSTATIC WATER THERMOTHER	6.41		Disagree	4.14
54065		DESTRUCTION, PENIS LESION(S)	2.42		Agree	2.42
54162 #		LYSIS PENIL CIRCUMCIS LESION	3.00		Agree	3.00
54163 #		REPAIR OF CIRCUMSION	3.00		Agree	3.00
54164 #		FRENULOTOMY OF PENIS	2.50		Agree	2.50
54400		INSERT SEMI-RIGID PROSTHESIS	8.99		Agree	8.99
54401		INSERT SELF-CONTD PROSTHESIS	10.28		Agree	10.28
54405		INSERT MULTI-COMP PENIS PROS	13.43		Agree	13.43
54406 #		REMOVE MULTI-COMP PENIS PROS	12.10		Agree	12.10
54408 #		REPAIR MUTLI-COMP PENIS PROS	12.75		Agree	12.75
54410 #		REMOVE/REPLACE PENIS PROSTH	15.50		Agree	15.50
54411 #		REMV/REPLC PENIS PROS, COMP	16.00		Agree	16.00
54415 #		REMOVE SELF-CONTD PENIS PROS	8.20		Agree	8.20
54416 #		REMV/REPL PENIS CONTAIN PROS	10.87		Agree	10.87
54417 #		REMV/REPLC PENIS PROS, COMPL	14.19		Agree	14.19
54512		EXCISE LESION TESTIS	8.58		Agree	8.58
56501		DESTROY, VULVA LESIONS, SIMP	1.53		Agree	1.53
56515		DESTROY VULVA LESION/S COMPL	1.88		Agree	1.88
56605		BIOPSY OF VULVA/PERINEUM	1.10		Agree	1.10
56810		REPAIR OF PERINEUM	4.13		Agree	4.13
57022		I & D VAGINAL HEMATOMA, PP	2.56		Agree	2.56
57061		DESTROY VAG LESIONS, SIMPLE	1.25		Agree	1.25
57065		DESTROY VAG LESIONS, COMPLEX	2.61		Agree	2.61
57155 #		INSERT UTERI TANDEMNS/OVOIDS	6.27		Agree	6.27
58100		BIOPSY OF UTERUS LINING	1.53		Agree	1.53
58346 #		INSERT HEYMAN UTERI CAPSULE	6.75		Agree	6.75
58563		HYSTEROSCOPY, ABLATION	6.17		Agree	6.17
58953 #		TAH, RAD DISSECT FOR DEBULK	32.00		Agree	32.00
58954 #		TAH RAD DEBULK/LYMPH REMOVE	35.00		Agree	35.00
59000		AMNIOCENTESIS, DIAGNOSTIC	1.30		Agree	1.30
59001 #		AMINOCENTESIS, THERAPEUTIC	3.00		Agree	3.00
64555		IMPLANT NEUROELECTRODES	2.27		Agree	2.27
64561 #		IMPLANT NEUROELECTRODES	6.74		Agree	6.74
64575		IMPLANT NEUROELECTRODES	4.53		Agree	4.53
64581 #		IMPLANT NEUROELECTRODES	13.50		Agree	13.50
64820		REMOVE SYMPATHETIC NERVES	10.37		Agree	10.37
64821 #		REMOVE SYMPATHETIC NERVES	8.75		Agree	8.75
64822 #		REMOVE SYMPATHETIC NERVES	8.75		Agree	8.75
64823 #		REMOVE SYMPATHETIC NERVES	10.37		Agree	10.37
66982		CATARACT SURGERY, COMPLEX	13.50		Agree	13.50
67225 #		EYE PHOTODYNAMIC THER ADD-ON	(a)		(a)	0.47
69990		MICROSURGERY ADD-ON	3.47		Agree	3.47
74230	26	CINE/VIDEO X-RAY, THROAT/ESO	0.53		Agree	0.53
74305	26	X-RAY BILE DUCTS/PANCREAS	0.42		Agree	0.42
76066	26	JOINT SURVEY, SINGLE VIEW	0.31		Agree	0.31
76078	26	RADIOGRAPHIC ABSORPTIONMETRY	0.20		Agree	0.20
76085 #	26	COMPUTER MAMMOGRAM ADD-ON	(a)		(a)	0.06
76120	26	CINE/VIDEO X-RAYS	0.38		Agree	0.38
76125	26	CINE/VIDEO X-RAYS ADD-ON	0.27		Agree	0.27
76362 #	26	CAT SCAN FOR TISSUE ABLATION	(a)		(a)	4.00
76394 #	26	MRI FOR TISSUE ABLATION	(a)		(a)	4.25
76490 #	26	US FOR TISSUE ABLATION	(a)		(a)	2.00

TABLE 6.—AMA RUC AND HCPAC WORK RVU RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2002 CPT CODES—Continued

*CPT CODE	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2002 work RVU
76819	26	FETAL BIOPHYS PROFIL W/O NST	0.63		Disagree	0.77
76885	26	US EXAM INFANT HIPS, DYNAMIC	0.74		Agree	0.74
76886	26	US EXAM INFANT HIPS, STATIC	0.62		Agree	0.62
77300	26	RADIATION THERAPY DOSE PLAN	0.62		Agree	0.62
77301 #	26	RADIOL THERAPY DOSE PLAN, IMRT	8.00		Agree	8.00
77418 #		RADIATION TX DELIVERY, IMRT	0.00		Agree	0.00
85097		BONE MARROW INTERPRETATION	0.94		Agree	0.94
88380 #	26	MICRODISSECTION	carrier		Agree	carrier
90471		IMMUNIZATION ADMIN	0.17		Disagree	0.00
90472		IMMUNIZATION ADMIN, EACH ADD	0.15		Disagree	0.00
90473 #		IMMUNE ADMIN ORAL/NASAL	0.17		Disagree	0.00
90939 #		HEMODIALYSIS STUDY, TRANSCUT	0.00		Agree	0.00
91123 #		IRRIGATE FECAL IMPACTION	0.00		Agree	0.00
92136 #	26	OPHTHALMIC BIOMETRY	0.54		Agree	0.54
92973 #		PERCUT CORONARY THROMBECTOMY.	3.28		Agree	3.28
92974 #		CATH PLACE, CARDIO BRACHYTX	3.00		Agree	3.00
93025 #		MICROVOLT T-WAVE ASSESS	0.75		Agree	0.75
93609	26	MAP TACHYCARDIA, ADD-ON	(a)		Disagree	4.81
93612	26	INTRAVENTRICULAR PACING	3.02		Agree	3.02
93613 #	26	ELECTROPHYS MAP, 3D, ADD-ON	carrier		Disagree	7.00
93619	26	ELECTROPHYSIOLOGY EVALUATION	7.32		Agree	7.32
93620	2	ELECTROPHYSIOLOGY EVALUATION	11.59		Agree	11.59
93621	26	ELECTROPHYSIOLOGY EVALUATION	2.10		Agree	2.10
93622	26	ELECTROPHYSIOLOGY EVALUATION	3.10		Agree	3.10
93701 #	26	BIOIMPEDANCE, THORACIC	0.00		Disagree	0.17
94720	26	MONOXIDE DIFFUSING CAPACITY	0.26		Agree	0.26
94750	26	PULMONARY COMPLIANCE STUDY	0.23		Agree	0.23
95144		ANTIGEN THERAPY SERVICES	0.06		Agree	0.06
95145		ANTIGEN THERAPY SERVICES	0.06		Agree	0.06
95165		ANTIGEN THERAPY SERVICES	0.06		Agree	0.06
95170		ANTIGEN THERAPY SERVICES	0.06		Agree	0.06
95250 #		GLUCOSE MONITORING, CONT	0.00		Agree	0.00
95875	26	LIMB EXERCISE TEST	1.10		Agree	1.10
95904	26	SENSE NERVE CONDUCTION TEST	0.34		Agree	0.34
95965 #	26	MEG, SPONTANEOUS	8.00		Agree	8.00
95966 #	26	MEG, EVOKED, SINGLE	4.00		Agree	4.00
95967 #	26	MEG, EVOKED, EACH ADDL	3.50		Agree	3.50
96000 #		MOTION ANALYSIS, VIDEO/3D		carrier	Disagree	1.80
96001 #		MOTION TEST W/FT PRESS MEAS		carrier	Disagree	2.15
96002 #		DYNAMIC SURFACE EMG		carrier	Disagree	0.41
96003 #		DYNAMIC FINE WIRE EMG		carrier	Disagree	0.37
96004 #		PHYS REVIEW OF MOTION TESTS		carrier	Disagree	1.80
96150 #		ASSESS HLTH/BEHAVE, INIT		0.50	Agree	0.50
96151 #		ASSESS HLTH/BEHAVE, SUBSEQ		0.48	Agree	0.48
96152 #		INTERVENE HLTH/BEHAVE, INDIV		0.46	Agree	0.46
96153 #		INTERVENE HLTH/BEHAVE, GROUP		0.10	Agree	0.10
96154 #		INTERV HLTH/BEHAV, FAM W/PT		0.45	Agree	0.45
96155 #		INTERV HLTH/BEHAV FAM NO PT		0.44	Agree	0.44
96567 #		PHOTODYNAMIC TX, SKIN	0.00		Agree	0.00
97005 #		ATHLETIC TRAIN EVAL		(a)	Agree	0.00
97006 #		ATHLETIC TRAIN REEVAL		(a)	Agree	0.00
97112		NEUROMUSCULAR REEDUCATION		0.45	Agree	0.45
97504		ORTHOTIC TRAINING		0.45	Agree	0.45
97535		SELF CARE MNGMENT TRAINING		0.45	Agree	0.45
97601		WOUND CARE SELECTIVE		0.50	Agree	0.50
97602		WOUND CARE NON-SELECTIVE		0.32	Disagree	0.00
99090		COMPUTER DATA ANALYSIS	0.00		Agree	0.00
99091 #		COLLECT/REVIEW DATA FROM PT	1.10		Disagree	0.00
99289 #		PT TRANSPORT, 30-74 MIN	4.80		Disagree	0.00
99290 #		PT TRANSPORT, ADDL 30 MIN	2.40		Disagree	0.00
99374		HOME HEALTH CARE SUPERVISION	1.10		Agree	1.10
99375		HOME HEALTH CARE SUPERVISION	1.73		Agree	1.73
99377		HOSPICE CARE SUPERVISION	1.10		Agree	1.10
99378		HOSPICE CARE SUPERVISION	1.73		Agree	1.73
99379		NURSING FAC CARE SUPERVISION	1.10		Agree	1.10
99380		NURSING FAC CARE SUPERVISION	1.73		Agree	1.73
99381		PREV VISIT, NEW, INFANT	1.19		Agree	1.19
99382		PREV VISIT, NEW, AGE 1-4	1.36		Agree	1.36

TABLE 6.—AMA RUC AND HCPAC WORK RVU RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2002 CPT CODES—Continued

*CPT CODE	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2002 work RVU
99383		PREV VISIT, NEW, AGE 5-11	1.36		Agree	1.36
99384		PREV VISIT, NEW, AGE 12-17	1.53		Agree	1.53
99385		PREV VISIT, NEW, AGE 18-39	1.53		Agree	1.53
99386		PREV VISIT, NEW, AGE 40-64	1.88		Agree	1.88
99387		PREV VISIT, NEW, 65 & OVER	2.06		Agree	2.06
99391		PREV VISIT, EST, INFANT	1.02		Agree	1.02
99392		PREV VISIT, EST, AGE 1-4	1.19		Agree	1.19
99393		PREV VISIT, EST, AGE 5-11	1.19		Agree	1.19
99394		PREV VISIT, EST, AGE 12-17	1.36		Agree	1.36
99395		PREV VISIT, EST, AGE 18-39	1.36		Agree	1.36
99396		PREV VISIT, EST, AGE 40-64	1.53		Agree	1.53
99397		PREV VISIT, EST, 65 & OVER	1.71		Agree	1.71

([a]) No RUC recommendation provided.
New CPT codes.
*All CPT codes copyright 2002 American Medical Association.

Table 7, AMA RUC Anesthesia Recommendations and CMS Decisions for New and Revised 2002 CPT Codes, lists the new or revised CPT codes for anesthesia and their base units that will be interim in 2002. This table includes the following information:

- CPT code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the base units recommended by the RUC.
- CMS decision. This column indicates whether we agreed with the RUC recommendation (''agree'') or we disagreed with the RUC recommendation (''disagree''). Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table.
- 2002 Base Units. This column establishes the 2002 base units for these services.

TABLE 7.—AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2002 CPT CODES

*CPT code	Description	RUC recommendation	CMS decision	2002 Base units
00797	ANESTH, SURGERY FOR OBESITY	9	Disagree	8
00851	ANESTH, TUBAL LIGATION	6	Agree	6
00869	ANESTH, VASECTOMY	3	Agree	3
01905	ANES, SPINE INJECT, X-RAY/RE	5	Agree	5
01916	ANESTH, DX ARTERIOGRAPHY	5	Agree	5
01924	ANES, THER INTERVEN RAD, ART	5	Agree	5
01925	ANES, THER INTERVEN RAD, CAR	7	Agree	7
01926	ANES, TX INTERV RAD HRT/CRAN	8	Agree	8
01930	ANES, THER INTERVEN RAD, VEI	5	Agree	5
01931	ANES, THER INTERVEN RAD, TIP	7	Agree	7
01932	ANES, TX INTERV RAD, TH VEIN	6	Agree	6
01933	ANES, TX INTERV RAD, CRAN V	7	Agree	7
01951	ANESTH, BURN, LESS 4 PERCENT	3	Agree	3
01952	ANESTH, BURN, 4–9 PERCENT	5	Agree	5
01960	ANESTH, VAGINAL DELIVERY	5	Agree	5
01961	ANESTH, CS DELIVERY	7	Agree	7
01962	ANESTH, EMER HYSTERECTOMY	8	Agree	8
01963	ANESTH, CS HYSTERECTOMY	8	Agree	8
01964	ANESTH, ABORTION PROCEDURES	4	Agree	4
01967	ANESTH/ANALG, VAG DELIVERY	5	Agree	5
01968	ANES/ANALG CS DELIVER ADD-ON	3	Disagree	2
01969	ANESTH/ANALG CS HYST ADD-ON	5	Agree	5

*All CPT codes copyright 2002 American Medical Association.

Discussion of Codes for Which There Were No RUC Recommendations or for which the RUC Recommendations Were Not Accepted

The following is a summary of our rationale for not accepting particular RUC work RVU or base unit recommendations. It is arranged by type of service in CPT code order. Additionally, we also discuss those CPT codes for which we received no RUC recommendations for physician work RVUs. This summary refers only to work RVUs.

Anesthesia for Intraperitoneal Procedures in Upper Abdomen Including Laparoscopy; Gastric Restrictive Procedure for Morbid Obesity (CPT Code 00797).

The RUC recommended that 9 base units be assigned to this procedure

based on a comparison to CPT code 00790 (Anesthesia for intraperitoneal procedures in the upper abdomen including laparoscopy; not otherwise specified). We disagree. We believe that assigning 9 base units to 00797 creates a rank order anomaly with CPT code 00794 (Anesthesia for intraperitoneal procedures in the upper abdomen including laparoscopy; pancreatectomy, partial or total (for example, Whipple procedure)) which is assigned 8 base units.

While obese patients do make the work of an anesthesiologist more difficult, we believe that the vignette used in the RUC survey was atypical and exaggerated the required work because the patient in the vignette was described as having asthma. We believe the work of an anesthesiologist is greater for patients undergoing Whipple procedures because, typically, these patients are sicker and require longer operative time and more intense anesthesia care than patients undergoing gastric restrictive procedures. Therefore, we are assigning 8 base units to 00797.

Cesarean Delivery Following Neuraxial Labor Analgesia/Anesthesia (List Separately in Addition to Code for Primary Procedure (CPT Code 01968))

The RUC recommended 3 base units for this add-on procedure. This procedure is reported in addition to *CPT code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor))*, when a patient who has been given neuraxial anesthesia for a planned vaginal delivery requires conversion to a cesarian delivery and must be given anesthesia for the cesarian delivery. The RUC recommended 7 base units for CPT code 01961 (Anesthesia for, cesarian delivery only), a recommendation with which we agree. We note the following:

- The base units of 01961, anesthesia for cesarian delivery, are the same as the base units of 01967 plus 01968.
- The survey respondents valued the add-on code 01968 as if it were a stand-alone code with a median base unit of 7 and an intraservice time of 75 minutes. Both the median base units and the intraservice time are identical to the survey results for 01961.
- CPT code 01968 is currently reported (per the American Society of Anesthesiologists) as *00857 (Neuraxial analgesia/anesthesia for labor ending in a cesarian delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)*, which is valued at 7 base units. Moreover, the work of CPT code 01967 plus CPT code 01968 is completely described by CPT code 00857 so it is unclear why the sum of the base units assigned to 01967 and 01968 should not be identical to the base units currently assigned to CPT code 00857.

In view of these concerns, we are assigning 2 base units to CPT code 01968. We are also making a neutrality adjustment to the anesthesia conversion factor based on our analysis of the estimated difference in base units between previously repeated anesthesia codes and the new codes.

Injection, Therapeutic (Eg, Local Anesthetic, Corticosteroid); Carpal Canal, (CPT Code 20526) Injection; Tendon Sheath, Ligament, Ganglion Cyst, (CPT Code 20550)

Injection; Tendon Origin/Insertion, (CPT Code 20551)

Injection; Single or Multiple Trigger Point(s), One or Two Muscle Group(s) (CPT Code 20552), and

Injection; Single or Multiple Trigger Point(s), Three or More Muscle Groups (CPT Code 20553)

CPT codes 20526, 20551, 20552, and 20553 are new codes, while 20550 is being revised from its current descriptor ''Injection, tendon sheath, ligament; ganglion cyst, or trigger points'' to the descriptor above. We received an interim recommendation of 0.86 work RVUs for these codes, from the RUC, based on the fact that all these procedures are currently reported as 20550 which is valued at 0.86 RVUs.

CPT code 20550 comprises several procedures with varying amounts of physician work that will now be reported separately. We are assigning 0.86 RVUs to all these codes on an interim basis, and will review this further for 2002 if we receive recommendations from the RUC. At that time we will also have utilization data on these services to assist us in making work neutrality adjustments should any adjustments be required.

Laparoscopy, Surgical; Colectomy, Partial With Anastomosis (CPT Code 44204) and Laparoscopy, Surgical; Colectomy, Partial, With Removal of Terminal Ileum With Ileocecostomy (CPT Code 44205)

The RUC recommended 22.00 RVUs for CPT code 44204 and 19.50 RVUs for CPT Code 44205 based on the reference code 44140 (*Colectomy, partial; with anastomosis*) which, at the time of the recommendation, had a work RVU of 18.35. We increased the work RVU of CPT Code 44140 to 21 as part of the 5-year review of physician work. In order to prevent rank order anomalies we are assigning work RVUs of 25.08 and 22.23 to CPT Codes 44204 and 44205, respectively. These work RVUs represent a 14 percent increase over the RUC recommendation and are consistent with our valuation of CPT Code 44140.

Laparoscopy, Surgical, Ablation of One or More Liver Tumor(s); Radiofrequency (CPT Code 47370), Laparoscopy, Surgical, Ablation of One or More Liver Tumor(s); Cryosurgical (CPT Code 47371), Ablation, Open, of One or More Liver Tumor(s); Radiofrequency (CPT Code 47380), Ablation, Open, of One or More Liver Tumor(s); Cryosurgical (CPT Code 47381), Ablation, One or More Liver Tumor(s), Percutaneous, Radiofrequency (CPT Code 47382), Computerized Axial Tomography Guidance for, and Monitoring of, Tissue Ablation (CPT Code 76362), Magnetic Resonance Guidance for, and Monitoring of, Tissue Ablation (CPT Code 76394); and Ultrasound Guidance for, and Monitoring of, Tissue Ablation (CPT Code 76490)

We have not received recommendations from the RUC for these procedures. We have assigned work RVUs as follows:

47370—18 work RVUs
47371—16.94 work RVUs
47380—21.25 work RVUs
47381—21.00 work RVUs
47382—12.00 work RVUs

To arrive at the values listed above, we compared the time and intensity of these services to other open and laparoscopic liver, colon, and renal procedures. We believe that the RVUs assigned place them in the correct rank order with these other services and with respect to each other.

76362—4.00 work RVUs
76394—4.25 work RVUs
76490—2.00 work RVUs

To arrive at the values above, we compared the time and intensity of these procedures to other radiologic guidance codes and to radiologic supervision and interpretation codes. We believe that the assigned RVUs place them in correct rank order to other radiologic guidance services and to each other.

Cystourethroscopy with irrigation and evacuation of clots, (CPT Code 52001)

The RUC recommended 5.45 work RVUs based on a comparison to the reference procedures *CPT code 52315 (Cystourethroscopy, with removal of*

foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated), and *CPT Code 52235 (Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; medium bladder tumor(s) (2.0 to 5.0 cm)).*

We are concerned that 52001, with its current descriptor, will be reported whenever a cystoscopy is performed and blood is present during the examination. As written, the code may be reported whenever any blood clots are present. The RUC recommendation is based upon the urologists' response to a scenario where the bladder outlet was obstructed due to large blood clots and removal of the blood clots required a resectoscope. Unfortunately, the code descriptor does not require the presence of bladder obstruction due to blood clots, nor does it require the use of a resectoscope. Therefore, until the descriptor of this code is clarified by the AMA CPT editorial panel, we are assigning 2.37 RVUs to this procedure. As the CPT code is now written, the time and intensity of the physician work for this procedure are comparable to CPT Code 52005. *(Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service).*

Transurethral Destruction of Prostatic Tissue; By Water Induced Thermotherapy (CPT Code 53853)

The RUC recommended 6.41 work RVUs for this procedure based on a comparison to CPT Code 54670 (Suture or repair of testicular injury) which has a similar work value and similar pre-, intra-, and postservice times to the median times in the survey for 53853. The RUC also noted that *CPT Code 53850 (Transurethral destruction of prostate; by microwave thermotherapy)* has 90 minutes of intraservice time as compared to 60 minutes for CPT code 53853 and that the recommended work value for CPT code 53853 was approximately ⅔ of the work value for CPT code 53850.

We note that although the intraservice time for CPT code 53853 is 60 minutes, most of that time is spent monitoring the flow of hot water through a catheter and balloon and checking the water's temperature. We estimate that the maximum amount of time spent on activities other than monitoring is 20 minutes. This means that the work intensity for the intraservice portion of this procedure is significantly less than it is for most other surgical procedures and, specifically, the reference codes examined by the RUC. Therefore, we believe it is more appropriate to compare CPT code 53853 to 90-day global procedures with less than 30 minutes of intraservice time. For these reasons we compared CPT code 58350 to the following procedures:

CPT code	Work RVU	Intraservice time (minutes)	Pre/post service time
53853 Transurethral destruction of prostate tissue; by water-induced thermotherapy.	RUC Recommendation—6.41	60	*113
	CMS assigned RVU 4.14.		
30130 Excision turbinate, partial or complete, any method	3.38	27	78
42826 Tonsillectomy, primary or secondary; age 12 or over	3.38	28	82
46045 Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia.	4.32	25	206
46946 Ligation of internal hemorrhoids; multiple procedures	3.0	25	75
58800 Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach.	4.14	23	100
61105 Twist burr hole for subdural or ventricular puncture	5.14	27	97
65810 Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection.	4.87	28	104
67031 Severing of vitreous strands, vitreous face adhesions, sheets, membranes, or opacities, laser surgery (one or more stages).	3.67	26	79

*see below.

The RUC sent us a postservice time of 131 minutes, which we believe is incorrect. The RUC assigned 3 postservice visits to this procedure which have a combined time of 35 minutes, not 53 minutes as recommended by the RUC. Therefore, the correct postservice time is 118 minutes.

With respect to the services listed above, we note that all of them carry significant risks to the patient and have intraservice work of high intensity. In fact, we believe the intraservice work of all the above procedures is of greater intensity than any portion of the intraservice work of CPT code 53853. After review of the procedures considered by the RUC and the above procedures, we believe that the time and intensity of CPT code 53853 is most comparable to CPT code 58800 and are assigning 4.14 work RVUs to CPT code 53853. This places CPT code 53853 in the correct rank order with respect not only to the procedures listed above but also to the prostate ablation, cystourethroscopy, and testicular procedures considered by the RUC.

Destruction of Localized Lesion of Choroids (eg, Choroidal Neovascularization); Photodynamic Therapy, Second Eye, at Single Session (List Separately in Addition To Code for Primary Eye Treatment) CPT Code 67225

We did not receive a RUC recommendation on this code. We are assigning work RVUs of 0.47, which is the work value for G0184, the code previously used for reporting this service.

Immunization Administration (Includes Percutaneous, Intradermal, Subcutaneous, Intramuscular and Jet Injections); One Vaccine (Single or Combination Vaccine/Toxoid) (CPT Code 90471), Immunization Administration (Includes Percutaneous, Intradermal, Subcutaneous, Intramuscular and Jet Injections); Each Additional Vaccine/Toxoid (List Separately in Addition To Code for Primary Procedure) One Vaccine (CPT Code 90472)

The RUC recommended a work RVU of .17 for CPT code 90471 and .15 work RVUs for CPT code 90472. These

services are analogous to *CPT code 90872 (Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular)* which has no physician work RVUs. They are services performed by a nurse and have no physician work. If the physician performs any counseling related to this service, it is considered part of the work of the preventive medicine visit during which the immunization was administered. If the vaccine is administered during a visit other than a preventive medicine service, any physician counseling should be billed separately as an E/M service. For these reasons we are not assigning work RVUs to these codes.

Immunization Administration by Intranasal or Oral Route; One Vaccine (Single or Combination Vaccine/Toxoid) (CPT Code 90473); and, Immunization Administration by Intranasal or Oral Route Each Additional Vaccine/Toxoid (List Separately in Addition To Code for Primary Procedure) CPT Code 90474

The RUC recommended a work RVU of .17 for CPT code 90473 and .15 work RVUs for CPT code 90474. These are noncovered services. Medicare does not cover self-administered vaccines, and, therefore, we are not assigning work RVUs to these services.

Intraventricular and/or Intra-Atrial Mapping of Tachycardia Site(s) With Catheter Manipulation to Record From Multiple Sites to Identify Origin of Tachycardia (CPT Code 93609)

We have not received a recommendation from the RUC for this service. The descriptor for this service has not changed but the AMA CPT editorial panel changed the global period for this service from a zero day global to a ZZZ global. This means that it is now an ''add on'' code and the physician work RVUs will no longer include any pre- or postservice work. It currently has a work RVU of 10.07. In order to appropriately value this add on service, we compared it to several other electrophysiology services, including *CPT code 93619, (Comprehensive electrophyisologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; without induction or attempted induction of arrhythmia)* with a work RVU of 7.32, and *CPT code 93618, Induction of arrhythmia by electrical pacing (work RVU 4.26),* and *CPT code 93624, (Electrophysiologic follow up study with pacing and recording to test effectiveness of therapy, including induction of attempted induction of arrhythmia),* with a work RVU of 4.81. After reviewing these services, we believe that the time and intensity of physician work for CPT code 93609 as an add-on code is most similar to CPT code 93624 and are assigning a work RVU of 4.81 to CPT code 93609.

Intracardiac Electrophysiologic 3-Dimensional Mapping (CPT Code 93613)

This is a new add-on code for which we have not received a recommendation from the RUC. As an add-on code, this service does not include and pre- or postservice work. We compared this service to *CPT code 93619 (Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; without induction or attempted induction of arrhythmia)* with work RVUs of 7.32 and to *CPT code 93651 (Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination)* with work RVUs of 16.25. We also wanted to ensure that the work value for this service was placed in correct rank order to CPT code 93609 (see above). We believe that the intraservice time and intensity of this service is slightly less than that of CPT code 93619 and are assigning 7.00 work RVUs to CPT code 93613.

Bioimpedence, Thoracic, Electrical CPT Code 93701

We received a RUC recommendation that this service has no physician work. We currently cover this service under the HCPCS code M0302. We assigned 0.17 physician work RVUs to this service in the November 2000 final rule after conducting a notice and comment period. We will consider the RUC recommendation. If we considered changing the work RVUs for this service, we would discuss any proposed change in a future notice of proposed rule making. However, we are going to discontinue HCPCS code M0302 and will recognize CPT Code 93701 for this service.

Comprehensive Computer-Based Motion Analysis by Video-Taping And 3–D Kinematics (CPT Code 96000), Comprehensive Computer-Based Motion Analysis by Video-Taping and 3–D Kinematics; With Dynamic Plantar Pressure Measurements During Walking (CPT Code 96001), Dynamic Surface Electromyography, During Walking or Other Functional Activities, 1–12 Muscles (CPT Code 96002), Dynamic Fine Wire Electromyography, During Walking or Other Functional Activities, 1 Muscle (CPT Code 96003), and Physician Review and Interpretation of Comprehensive Computer Based Motion Analysis, Dynamic Plantar Pressure Measurements, Dynamic Surface Electromyography During Walking or Other Functional Activities, and Dynamic Fine Wire Electromyography, With Written Report (CPT Code 96004)

HCPAC recommended that these services be carrier priced. We disagree and are assigning work RVUs to these services as follows:

CPT code 96000—1.8 work RVUs
CPT code 96001—2.15 work RVUs
CPT code 96002—.41 work RVUs
CPT code 96003—.37 work RVUs
CPT code 96004—1.8 work RVUs

To arrive at these values, we compared the time and intensity of CPT codes 96000 and 96001 to other physical therapy services. We believe that the assigned RVUs place these services in the correct rank order with other physical therapy services. We compared the time and intensity of CPT codes 96002 and 96003 to other electromyography services and believe that the assigned RVUs place these services in the correct rank order with other electromyography services. We compared the time and intensity of CPT code 96004 with other physical therapy services and physician consultation services and believe the assigned RVUs place CPT code 96004 in the correct rank order with these other services.

Removal of Devitalized Tissue From Wound(s); Non-Selective Debridement, Without Anesthesia (eg, Wet-To-Moist Dressings, Enzymatic, Abrasion), Including Topical Applications(s), Wound Assessment and Instruction(s) for Ongoing Care, Per Session, CPT 97602

The HCPAC recommended a work RVU of .32 for this service. We disagree with this recommendation as we continue to believe that this code is bundled into 97602 for the reasons discussed earlier in this section. Therefore, we are not establishing work RVUs for this service.

Collection and Interpretation of Physiologic Data (eg, ECG, Blood Pressure, Glucose Monitoring) Digitally Stored and/or Transmitted by the Patient and/or Caregiver to the Physician or Other Qualified Health Care Professional, Requiring a Minimum of 30 Minutes of Time CPT CODE 99091

The RUC recommended work RVUs of 1.10 for this code. We disagree as this work is considered part of the pre and postservice work of an E/M service and propose to bundle payment for this code. (Note that payment for similar *CPT code, 99090, Analysis of clinical data in computers (eg, ECGs, blood pressures, hematologic data,* is also currently bundled.)

CPT Codes 99289, Physician Constant Attention of the Critically Ill or Injured Patient During an Interfacility Transport; First 30–74 Minutes, and 99290 Each Additional 30 Minutes (List Separately in Addition To Code for Primary Service)

These two new codes were created for CPT 2002 that describe services provided during patient transport. The RUC recommended that CPT code 99289 be valued at 4.8 work RVUs and CPT code 99290 be valued at 2.4 work RVUs. The CPT explanatory notes accompanying these two new codes state:

The following codes 99289 and 99290 are used to report the physical attendance and direct face-to-face care by a physician during the interfacility transport of a critically ill or injured patient. For the purposes of reporting codes 99289 and 99290, face-to-face care begins when the physician assumes the primary responsibility of the patient at the referring hospital or facility, and ends when the receiving hospital or facility accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact the patient during the transport should be reported. Patient transport services involving less than 30 minutes of face-to-face physician care should not be reported using 99289, 99290.

Procedure(s) or service(s) performed by other members of the transporting team may not be reported by the supervising physician. Any procedure(s) or service(s) performed by the physician before or during transport that are identified in CPT may be reported separately with the exception of routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry) and the initiation of mechanical ventilation.

The time spent by the physician performing separately reportable services or procedures should not be included in the face-to-face time reported by codes 99289, 99290. The direction of emergency care to transporting staff by a physician located in a hospital or other facility by two-way communication is not considered direct face-to-face care and should not be reported with codes 99289, 99290.

The CPT explanatory notes go on to state that physicians should report emergency department services codes, initial hospital care codes, and critical care codes only after the patient has been admitted to the emergency department, the inpatient floor, or the critical care unit of the receiving facility.

Decision: We would like to note that, currently, physician services provided to patients during interfacility transport are reported, and paid, using the appropriate E/M service codes (for example, outpatient visits, emergency visits, prolonged services, critical care).

We have several significant concerns about the new CPT codes, 99289 and 99290. First, other than requiring face-to-face contact with the patient, there is no requirement for delivery of any specific physician service. This is in contrast to requirements for reporting critical care services under CPT codes 99291, 99292, 99295, 99296, 99297, and 99298. When reporting CPT codes 99291 and 99292 the CPT requires that, in addition to the patient being critically ill or critically injured, and the physician devoting his or her full attention to the patient, ''high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.'' These codes are valued at 4.0 work RVUs and 2.0 work RVUs, respectively.

The CPT goes on to state that—

''Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when those elements are not present.''

'' * * * Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided, meet the above requirements.''

As the code descriptors are written, the care described by the new CPT patient transport codes 99289 and 99290 do not meet the requirements for critical care. In fact, some services that will be reported as 99289 and 99290 would also be more appropriately reported as a new or established outpatient visit, an emergency visit, or as prolonged services, depending on the type of care that was delivered. We believe that the descriptors for CPT codes 99289 and 99290 will make it difficult for physicians to know when to report 99289 and 99290 appropriately.

Second, the beginning and ending times for 99289 and 99290 are unclear. We do not believe time spent in the referring and receiving facility should be counted towards this service. Time spent in the facility prior to and after transfer may not require any physician services even though the physician is face-to-face with the patient. Furthermore, if services are provided at the referring or receiving facility they should be billed as the appropriate E/M service (for example, new patient visit, emergency visit).

Third, we note that the descriptors for 99289 and 99290 include the phrase '' * * * critically ill or injured patient'' while the descriptors for 99291 and 99292 include the phrase '' * * * critically ill or critically injured patient.'' We realize that CPT descriptors are carefully developed, so we are concerned about this discrepancy and believe it needs to be clarified.

Fourth, we note that although CPT specifically includes (or bundles) certain services into critical care, it does not include those same services in the payment for 99289 and 99290 (for example, gastric intubation, temporary transcutaneous pacing).

Therefore, after careful review of the descriptors and explanatory notes for CPT codes 99289 and 99290, we have decided to not recognize these codes for Medicare purposes. Instead, we have created two HCPCS Level II codes to describe critical care services provided to patients during inter-facility transport. These codes are:

G0240—Critical Care Service delivered by a physician; face-to-face, during inter-facility transport of a critically ill or critically injured patient: first 30–74 minutes of active transport.

G0240 will be valued at 4.0 work RVUs.

G0241—each additional 30 minutes (list separately in addition to G0240)

G0241 will be valued at 2.0 work RVUs.

We believe that these two G codes carry out the intent of 99289 and 99290 with less ambiguity and thus will facilitate accurate reporting of these services by physicians. We have decided to value these services at the present value for 99291 (4.0 work RVUs) and 99292 (2.0 work RVUs). Although critical care is the most intense E/M service delivered by physicians, there is considerable variation in the intensity range of the services provided under the umbrella of critical care. We value all critical care services uniformly and do not believe there is a need to develop a

tiered approach to valuing critical care services.

We will apply all the requirements for critical care services (CPT codes 99291 and 99292) to G0240 and G0241 with the following two exceptions: (1) All time counted towards patient transport time must be face-to-face time with the patient; (2) We will only allow face-to-face time spent in actual transport to be counted towards G0240 and G0241; E/M services delivered in the referring and receiving facilities may be reported under other appropriate E/M codes (for example, outpatient, emergency, or critical care services).

If the actual transportation time is less than 30 minutes and/or the service does not meet the requirements of G0240 and G0241, then the physician may report his or her services under the appropriate E/M code (for example, outpatient visit, emergency visit, prolonged services).

In order for G0240 and G0241 to be payable, the medical record must document the time spent in actual patient transport, the nature of the patient's critical illness or critical injury, and the critical care services delivered to the patient. Consistent with the teaching physician policies in section 15016 of the Medicare Carriers Manual, residents who provide this service are paid through graduate medical education payments. Therefore, their services are not payable through Medicare Part B.

Any services delivered, or face-to-face time spent with the patient, by a resident, nurse, emergency medical technician, or other non-physician may not be billed using G0240 or G0241. Nor may any services performed by any physician or non-physician who is not physically present with the patient during interfacility transport be billed. Time spent in the referring facility, the receiving facility, and time spent prior to transport are not countable towards G0240 and G0241. Additionally, any time spent performing separately billable procedures may not be counted towards G0240 and G0241 (for example, insertion of chest tubes, insertion of intravenous lines and pacemakers, and cardiopulmonary resuscitation). All services bundled into 99291 and 99292 will also be bundled into G0240 and G0241.

Establishment of Interim Practice Expense Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New HCFA Common Procedure Coding System Codes for 2002

We have developed a process for establishing interim practice expense RVUs (PERVUs) for new and revised codes that is similar to that used for work RVUs. Under this process, the RUC recommends the practice expense direct inputs, that is, the staff time, supplies and equipment associated with each new code. We then review the recommendations in a manner similar to our evaluation of the recommended work RVUs.

The RUC recommendations on the practice expense inputs for the new and revised 2002 codes were submitted to us as interim recommendations. We, therefore, consider that these recommendations are still subject to further refinement by the PEAC, or by us, if it is determined that such future review is needed. We may also revisit these inputs in light of future decisions of the PEAC regarding supply and equipment packages and standardized approaches to pre- and postservice clinical staff times.

We have accepted, at least in the interim, almost all of the practice expense recommendations submitted by the RUC for the codes listed in table 6, AMA RUC and HCPAC Work RVU Recommendations and CMS Decisions for New and Revised 2002 CPT Codes.'' We made the following minor changes to the inputs where relevant:

- We substituted the RUC agreed-upon multispecialty minimum visit supply package for the list of individual supplies where appropriate.
- We deleted separately billable supplies, for example, drugs, fluids, casting supplies, when listed in the recommended supply list.
- We rounded fractions of minutes of clinical staff time to the nearest minute.
- The RUC agreed with the specialty society representing neurology that the magnetoencephalography codes, CPT 95965, 95966, 95967, are only performed in the facility setting and that they therefore had no direct practice expense inputs. However, we have subsequently heard from the specialty society that it has determined that a small number of practitioners do perform these services in the office setting and that there would be costs in that setting that should be reflected. We have accepted the suggestion that the TC of these codes be carrier-priced, at least until we can ascertain what direct cost inputs should be included when these services are performed in the non-facility setting.
- We are accepting the practice expense inputs recommended for CPT code *77418 (Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams (binary, dynamic, MLC, etc.)*, per treatment session, with the exception of the time for the radiation therapist which we are reducing from the recommended 123 minutes to 60 minutes. We are concerned that there may be overlap in the staff time for other codes billed in conjunction with CPT code 77418, such as CPT code *76950 (Ultrasound guidance for placement of radiation therapy fields)* and *CPT code 77417 (Therapeutic radiology port film(s)).*

Further, we understand that the code was valued assuming the typical time for the service was 60 minutes and included the time of two radiation therapists. We believe that the service commonly takes less than the recommended 123 minutes and it may involve only one therapist. As a result of these concerns, we are valuing the service using 60 minutes of radiation technician time. This valuation is considered interim during the refinement of practice expense RVUs. We also note that the practice expense RVUs for 77418 are being determined under the resource-based methodology even though the service has no physician work. We believe that the service will have a more appropriate relative payment amount if the practice expense RVUs are determined outside of the no work methodology.

- We did not receive a RUC recommendation for CPT code 93613, *Intracardiac electrophysiology,* or CPT 96004, *Gait and motion studies.* We have assumed that these services are performed only in the facility setting and have no direct inputs.

For the following CPT codes we did not receive practice expense recommendations. Therefore, we are providing practice expense inputs through crosswalking to an existing code as indicated below:

New/revised CPT code	Existing CPT/HCPCS code
20553 Therapeutic Injections	20550 Therapeutic Injections.
47370 Ablation of Hepatic Tumors	47562 Laparoscopic cholecystectomy.
47371 Ablation of Hepatic Tumors	47562 Laparoscopic cholecystectomy.
47380 Ablation of Hepatic Tumors	47350 Repair liver wound.

New/revised CPT code		Existing CPT/HCPCS code	
47381	Ablation of Hepatic Tumors	47350	Repair liver wound.
47382	Ablation of Hepatic Tumors	47525	Change bile duct catheter.
67225	Ocular Photodynamic Therapy	G0184	Ocular photodynamic tx, 2nd.
76362	Ablation of Hepatic Tumors	76360	CAT scan for needle biopsy.
76394	Ablation of Hepatic Tumors	76393	Mr guidance for needle place.
76490	Ablation of Hepatic Tumors	76942	Echo guide for biopsy.

C. Other Changes to the 2002 Physician Fee Schedule and Clarification of CPT Definitions

For the 2002 physician fee schedule, we are establishing or revising several alpha-numeric HCPCS codes for reporting certain services that are not clearly described by existing CPT codes.

In addition to the two new HCPCS codes for patient transport we have discussed in section IV.B., ''Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2002'' above; we are also establishing the HCPCS codes for the respiratory therapy services below.

Respiratory Therapy Codes

Respiratory therapists can deliver services incident to a physician's service or in a provider setting such as an outpatient hospital or a comprehensive outpatient rehabilitation facility. In the past, services delivered by respiratory therapists or other health professionals often have not been clearly described by the existing CPT codes. In order to clarify coding of these services, typically delivered by respiratory therapists, but at times delivered by other specially trained health professionals, we are instituting new G codes to describe these services.

We developed three codes for use to describe services to improve respiratory function:

G0237 Therapeutic Procedures To Increase Strength or Endurance of Respiratory Muscles, Face-to-Face, One-on-One, Each 15 Minutes (Includes Monitoring).

This service is to be billed when the therapist works with the patient to perform specific exercises aimed at strengthening the main and accessory muscles of respiration.

We have provided a specific value for this code based upon the time that a respiratory therapist, who we believe will be the typical professional providing this service, will spend performing this service and practice expenses crosswalked from other similar services. This code will have no physician work.

G0238 Therapeutic Procedures To Improve Respiratory Function, Other Than Ones Described by G0237, One-on-One, Face-to-Face, per 15 Minutes (Includes Monitoring)

G0239 Therapeutic Procedures To Improve Respiratory Function, Two or More Patients Treated During the Same Period, Face-to-Face (Includes Monitoring)

Codes G0237 and G0238 are billed in 15-minute increments. The method for ''counting'' the 15 minutes will be consistent with the method for counting minutes in many of the 97000 series CPT codes (see PM–01–68 for details). These codes would describe activities, such as monitored exercise, that improve respiratory function. Both G0238 and G0239 would be carrier-priced. The carriers have the authority to request information about the specific nature of the services delivered. CPT codes G0237–G0239 may not be billed with codes G0110 and G0111, which are restricted to services in the National Emphysema Treatment Trial (NETT), since they represent the same services.

These codes are designed to provide more specific information about the services being delivered. The availability of codes for services to improve respiratory function will make billing of CPT codes 97000–97799 inappropriate for professionals involved in treating respiratory conditions, unless these services are delivered by physical and occupational therapists and meet the other requirements for physical and occupational therapy services. We recognize that speech and language pathologists also occasionally treat patients to improve respiratory function as part of their treatment of speech and language disorders. Because the primary goal of these services is not to improve respiratory function, but to restore speech and communication, these services should be coded with 92507, ''treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation, individual).''

VI. Update of the Codes for the Physician Self-Referral Prohibition

On January 4, 2001 we published in the **Federal Register** a final rule with comment period, ''Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships'' (66 FR 856). That final rule incorporated into regulations the provisions in paragraphs (a), (b) and (h) of section 1877 of the Social Security Act (the Act). Section 1877 of the Act prohibits a physician from referring a Medicare patient for certain ''designated health services'' to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. In the final rule, we published an attachment listing all of the CPT and HCPCS codes that defined the entire scope of the following designated health services for purposes of section 1877 of the Act: clinical laboratory services; physical therapy services (including speech-language pathology services); occupational therapy services; radiology and certain other imaging services; and radiation therapy services and supplies.

In the January 4, 2001 final rule, we stated that we would update the list of codes used to define these designated health services in an addendum to the annual final rule concerning physician fee schedule payment policies. Thus, we are now publishing an updated all-inclusive list of codes at Addendum E. We also will provide that update on our website at *www.hcfa.gov/medlearn/refphys.htm.* The purpose of this update is to conform the code list to the most recent publication of CPT and HCPCS codes. The list of codes will become effective on January 4, 2002. We are using the January 4, 2002 date because that is the effective date for all but one provision of the January 4, 2001 physician self-referral final rule (changes made to 42 CFR 424.22 in the final rule became effective on April 6, 2001). In future years, we intend to use a January 1 effective date to coincide with the effective date of the new CPT and HCPCS codes.

Table 8, below, identifies the CPT and HCPCS codes that have been added to

or deleted from the list of codes published as an attachment to the January 4, 2001 physician self-referral final rule. In that final rule, we stated that we would consider timely comments regarding the updated code list. Accordingly, we will consider comments with respect to the codes listed in Table 8, below, if we receive them by the date specified in the date section of this final rule.

TABLE 8.—ADDITIONS AND DELETIONS TO THE PHYSICIAN SELF-REFERRAL CODES

CPT[1] or HCPCS code	
Additions	
76085	Computer mammogram add-on.
77301	Radioltherapy dos plan, imrt.
77418	Radiation tx delivery, imrt.
92974	Cath place, cardio brachytx.
96000	Motion analysis, video/3d.
96001	Motion test w/ft press meas.
96002	Dynamic surface emg.
96003	Dynamic fine wire emg.
G0202	Screening mammography digital.
G0204	Diagnostic mammography digital.
G0206	Diagnostic mammography digital.
G0236	Digital film convert diag ma.
J1270	Injection, doxercalciferol.
J1755	Iron sucrose injection.
Q3018	Hepatitis B vaccine.
Deletions	
90744	Hepb vacc ped/adol 3 dose im.
90746	Hep B vaccine, adult, im.
90747	Hepb vacc, ill pat 4 dose im.

[1] CPT codes, descriptions and other data only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

Table 8 includes 2 codes (J1270 and J1755) that we have identified as dialysis-related outpatient prescription drugs. The physician self-referral prohibition will not apply to these services if they meet the conditions set forth in § 411.355(g) concerning the exception to the physician self-referral rule for EPO and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility. Table 8 also includes codes (G0202, 76085 and Q3018) that we have identified as screening tests and a vaccine. The physician self-referral prohibition will not apply to these services if they meet the conditions at § 411.355(h) concerning the exception for preventive screening tests, immunizations, and vaccines.

We note that, in response to our January 4, 2001 final rule with comment, we received a number of comments regarding designated health services. We intend to address those comments in a second final rule regarding the physician self-referral prohibition.

VII. Physician Fee Schedule Update for Calendar Year 2002

A. Physician Fee Schedule Update

The physician fee schedule update for 2002 is –4.8 percent. Under section 1848(d)(3) of the Act, the update is equal to 1 plus the product of the Medicare Economic Index (MEI) (divided by 100) and 1 plus the update adjustment factor. For 2002, the MEI is equal to 2.6 percent (1.026). A more detailed description of the MEI and its calculation follows. The update adjustment factor is equal to –7.0 percent (0.930). Section 1848(d)(4)(F) of the Act requires an additional –0.2 percent (0.998) reduction to the update for 2002. Thus, the product of the MEI (1.026), the update adjustment factor (0.930), and the statutory adjustment factor (0.998) equals the 2002 update of –4.8 percent (0.9523). The MEI and the update adjustment factor are described below.

B. The Percentage Change in the Medicare Economic Index

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide labor productivity. This index, which has 1996 base weights, is comprised of two broad categories—physician's own time and physician's practice expense.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents—wages and salaries, and fringe benefits. These components are adjusted by the 10-year moving average annual percent change in output per man-hour for the nonfarm business sector to reflect productivity growth in physicians' offices.

The physician's practice expense category represents the rate of price growth in nonphysician inputs to the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. Like physician's own time, the nonphysician staff categories are adjusted for productivity using the 10-year moving average annual percent change in output per man-hour for the nonfarm business sector. The physician's practice expense component also includes the following categories of nonlabor inputs—office expense, medical materials and supplies, professional liability insurance, medical equipment, professional car, and other expense. Table 9 presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2002 update. The calendar year 2002 MEI is 2.6 percent.

TABLE 9.—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2002 [1]

Cost categories and price measures	1996 Weights [2]	CY 2002 percent changes
Medicare Economic Index Total	100.0	2.6
1. Physician's Own Time [3 4]	54.5	2.1

TABLE 9.—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2002 [1]—Continued

Cost categories and price measures	1996 Weights [2]	CY 2002 percent changes
a. Wages and Salaries: Average hourly earnings private nonfarm, net of productivity	44.2	2.0
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm, net of productivity	10.3	3.2
2. Physician's Practice Expense [3 4]	45.5	3.0
a. Nonphysician Employee Compensation	16.8	2.5
1. Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation, net of productivity	12.4	2.3
2. Fringe Benefits: Employment Cost Index, fringe benefits, white collar, net of productivity	4.4	3.7
b. Office Expense: Consumer Price Index forUrban Consumers (CPI–U), housing	11.6	4.2
c. Medical Materials and Supplies: Producer Price Index (PPI), ethical drugs/PPI, surgical appliances and supplies/CPI–U, medical equipment and supplies (equally weighted)	4.5	1.8
d. Professional Liability Insurance: HCFA professional liability insurance survey [5]	3.2	4.0
e. Medical Equipment: PPI, medical instruments and equipment	1.9	0.6
f. Other Professional Expense	7.6	2.8
1. Professional Car: CP–U, private transportation	1.3	3.9
Other: CPI–U, all items less food and energy	6.3	2.6
Addendum:		
Productivity: 10-year moving average of output per man-hour, nonfarm business sector	n/a	2.0
Physician's Own Time, not productivity adjusted	54.5	4.3
Wages and salaries, not productivity adjusted	44.2	4.1
Fringe benefits, not productivity adjusted	10.3	5.3
Nonphysician Employee Compensation, not productivity adjusted	16.8	4.7
Wages and salaries, not productivity adjusted	12.4	4.3
Fringe benefits, not productivity adjusted	4.4	5.9

[1] The rates of historical change are for the 12-month period endingJune 30, 2001, which is the period used for computing the calendar year 2002 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 18, 2001.

[2] The weights shown for the MEI components are the 1996 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for calendar year 1996. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 1996 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

[3] The Physician's Own Time and Nonphysician Employee Compensation category price measures include an adjustment for productivity. The price measure for each category is divided by the 10-year moving average of output per man-hour in the nonfarm business sector. For example, the fringe benefits component of the Physician's Own Time category is calculated by dividing the rate of growth in the employment cost index-benefits for private, nonfarm workers by the 10-year moving average rate of growth of output per man-hour for the nonfarm business sector. Dividing one plus the decimal form of the percent change in the employment cost index-benefits (1+.053=1.053) by one plus the decimal form of the percent change in the 10-year moving average of labor productivity(1+.020=1.020) equals one plus the change in the employment cost index-benefits for white collar workers net of the change in output per manhour (1.053/1.020=1.032). All Physician's Own Time and Nonphysician Employee Compensation categories are adjusted in this way. Due to a higher level of precision the computer calculated quotient may differ from the quotient calculated from rounded individual percent changes.

[4] The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics website—http://stats.bls.gov.

[5] Derived from a CMS survey of several major insurers (the latest available historical percent change data are for the period ending second quarter of 2001).

[7/a] Productivity is factored into the MEI compensation categories as an adjustment to the price variables; therefore, no explicit weight exists for productivity in the MEI.

C. The Update Adjustment Factor

Paragraphs (3) and (4) of section 1848(d)(3) of the Act indicate that the physician fee schedule update is equal to the product of the Medicare Economic Index and an ''update adjustment factor.'' The update adjustment factor is applied to the inflation update to reflect success or failure in meeting the expenditure target that the law refers to as ''allowed expenditures.'' Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR is a percentage increase that is determined by a formula specified in section 1848(f) of the Act. The next section of this final rule describes the SGR and its calculation in detail. The update adjustment factor is determined based on a comparison of actual and allowed expenditures. For years beginning with 1999, the BBA required that the update adjustment factor be determined under section 1848(d)(3) of the Act to equal—

- The difference between (1) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year involved, and (2) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by—
- The actual expenditures for physicians' services for the 12-month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

The BBRA made changes to the methodology for determining the physician fee schedule update beginning in 2001. In particular, it established that the methodology in section 1848(d)(3) of the Act would only be used for determining the physician fee schedule update for 1999 and 2000; the physician fee schedule update for 2001 and subsequent years is determined under section 1848(d)(4) of the Act. While the general principle of adjusting the inflation update (the MEI) based on a comparison of actual and target expenditures (the update adjustment factor) is continuing, the BBRA made fundamental changes to the calculation of the update adjustment factor. These changes do two things. First, the measurement of actual

expenditures will occur on the basis of a calendar year rather than a April 1 to March 31 year. This essentially conforms the measurement of actual expenditures with other aspects of the SGR system that are also occurring on the basis of a calendar year as a result of BBRA amendments. As explained in our April 10, 2000 SGR notice (65 FR 19000), the BBRA essentially changed the SGR system from one that spanned 3 different time periods (1—Measurement of actual expenditures on the basis of a April 1 to March 31 period; 2—calculation of the SGR rate of increase on a Federal fiscal year basis; and 3—application of the update on a calendar year basis) to one that spans only one time period (all three elements are computed on the basis of a calendar year). Second, it ensures that any deviation between cumulative actual expenditures and cumulative allowed expenditures will be corrected over several years rather than in a single year. This will result in less year-to-year volatility in the physician fee schedule update than will occur if adjustments to the update are made to bring expenditures in line with the target in one year.

Under section 1848(d)(4)(A) of the Act, the physician fee schedule update for a year is equal to the product of—(1) 1 plus the Secretary's estimate of the percentage increase in the MEI for the year, and (2) 1 plus the Secretary's estimate of the update adjustment factor for the year. Under section 1848(d)(4)(B) of the Act, the update adjustment factor for a year beginning with 2001 is equal to the sum of the following—

- Prior Year Adjustment Component. An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for such services for that year;

+ Dividing that difference by the amount of the actual expenditures for such services for that year; and

+ Multiplying that quotient by 0.75.

- Cumulative Adjustment Component. An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996 through the end of the prior year and the amount of the actual expenditures for such services during that period;

+ Dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate for the year for which the update adjustment factor is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(D) of the Act indicates that the update adjustment factor determined under section 1848(d)(4)(B) for a year may not be less than −0.07 or greater than 0.03. At this time, we estimate that the sum of the prior year and cumulative adjustment components will be less than −0.07 limit. In a letter to the Medicare Payment Advisory Commission and in data we made available to the public on the CMS website in March, we indicated that the estimated update adjustment factor for 2002 would be −1.5 percent. However, we also indicated that a number of factors could change our estimate of the update adjustment factor. Since our March estimate, a number of factors have changed that lower our estimate of allowed expenditures and increase our estimate of actual expenditures. Allowed expenditures have declined because real per capita gross domestic product (GDP) growth for 2000 is lower than the estimates in March. This occurs because of changes to economic figures for 2000 made at the Bureau of Economic Analysis. Further, current estimates of real GDP per capita growth for 2001 and 2002 are lower than in March. We provide a more detailed explanation of factors that affect our estimate of allowed expenditures in the next section of this final regulation on the SGR. An explanation of changes to actual expenditures follows.

As indicated above, we are currently estimating higher 2001 actual expenditures than we did in March. We did not have any Medicare claims data to develop our March estimates of actual expenditures for 2001. At this time, we are using claims received through June 30 to estimate actual expenditures for all of 2001. Based on the claims received in the first half of the year, our current estimates of actual expenditures for 2001 are higher than earlier estimates. We will be revising the measurement of actual expenditures for CY 2001 based on claims received through June 30, 2002. These revised figures will be determined no later than November 1, 2002. If the revised figures are different than current estimates, the difference will be reflected in the update adjustment factor used in determining the 2003 physician fee schedule update.

After taking into account the factors described above that affect allowed and actual expenditures, we originally estimated that the update adjustment factor for 2002 would be −5.4 percent or 1.6 percentage points more than the −7.0 percent limit on the update adjustment factor. However, in making updates to the list of codes that are included in the SGR, we discovered that a number of new procedure codes were inadvertently not included in the measurement of actual expenditures beginning in 1998. Therefore, the measurement of actual expenditures for 1998, 1999, and 2000 was lower than it should have been. As a result, the physician fee schedule update was higher in 2000 and 2001 than if we had included these codes. Including these codes in the measurement of actual expenditures results in a lower update adjustment factor than we earlier estimated. We will be making no changes to physician fee schedule payments made for services furnished in 2000 and 2001. However, under section 1848(d) of the Act, we must include these codes in the measurement of actual expenditures for historical, current, and future periods. While we do not currently know the precise effect of not measuring expenditures for all codes included in the SGR on the update adjustment factor for 2002, we are certain that it is in excess of 1.6 percentage points and is of sufficient magnitude to result in the update adjustment factor being less than the −7.0 percent statutory limit. In the near future, we expect to complete this analysis and update information that we make available on the CMS website. We plan to provide complete data that show quarterly allowed and actual expenditures for all procedure codes included in the SGR, as well as a list of the codes themselves.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1 should be added to the update adjustment factor determined under section 1848(d)(4)(B) of the Act. Thus, adding 1 to −0.070 makes the update adjustment factor equal to 0.930.

(As indicated in the SGR discussion below, allowed expenditures through the end of CY 2001 will be revised one more time, not later than November 1, 2002. We will also be revising the measurement of actual expenditures for CY 2001 based on claims received through June 30, 2002, not later than November 1, 2002. The SGR for 2001 will also be revised one more time, and the SGR for 2002 will be revised two more times. The resulting effect from revisions of estimates will be reflected in the update adjustment factor determined for 2003.)

VIII. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

Section 1848(f) of the Act, as amended by section 4503 of the BBA, replaced the Medicare Volume Performance Standard (MVPS) with a Sustainable Growth Rate (SGR). Section 1848(f)(2) of the Act specifies the formula for establishing yearly SGR targets for physicians' services under Medicare. The use of SGR targets is intended to control the actual growth in aggregate Medicare expenditures for physicians' services.

The SGR targets are not limits on expenditures. Payments for services are not withheld if the SGR target is exceeded by actual expenditures. Rather, the appropriate fee schedule update, as specified in section 1848(d)(3) of the Act, is adjusted to reflect the success or failure in meeting the SGR target. If expenditures exceed the target, the update is reduced. If expenditures are less than the target, the update is increased.

As with the MVPS, the statute specifies a formula to calculate the SGR based on our estimate of the change in each of four factors. The four factors for calculating the SGR are as follows—

(1) The estimated change in fees for physicians' services.

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries.

(3) The estimated projected growth in real GDP per capita.

(4) The estimated change in expenditures due to changes in law or regulations.

Section 211 of the BBRA amended sections 1848(d) and 1848(f) of the Act with respect to the physician fee schedule update and the SGR. Section 211(b) of the BBRA maintains the formula for calculating the SGR, but amends section 1848(f)(2) of the Act to apply the SGR on a calendar year (CY) basis beginning with 2000 while maintaining the SGR on a fiscal year (FY) basis for FY 1998 through FY 2000. Specifically, section 1848(f)(2) of the Act, as amended by section 211(b) of the BBRA, states that ''* * * [t]he sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 shall be equal to the product of—

(1) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the applicable period involved,

(2) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous applicable period to the applicable period involved,

(3) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous applicable period to the applicable period involved; and

(4) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the applicable period (compared with the previous applicable period) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under section 1848 (d)(3)(B) or (d)(4)(B) of the Act, as the case may be, minus 1 and multiplied by 100.''

Under section 1848(f)(4)(C) of the Act, the term ''applicable period'' means—(1) a FY, in the case of FY 1998, FY 1999 and FY 2000, and (2) a CY with respect to a year beginning with 2000.

Section 1848(d)(4)(C) of the Act requires us to make the transition from a FY SGR to a CY SGR in 1999 by using the FY 1999 SGR for the first 3 months of 1999 and the FY 2000 SGR for the 9-month period beginning April 1, 1999. Allowed expenditures for the year are equal to the sum of allowed expenditures for each respective period. The SGR for CY 2000 is then applied to allowed expenditures for CY 1999.

As stated in the April 10, 2000 final notice (65 FR 19000), the BBRA requires the estimates of the FY 2000 and CY 2000 SGRs to be revised based on more recent data, but, as explained below, the BBRA does not provide for revision of either the FY 1998 or the FY 1999 SGR. This means that, for the transition to a calendar year SGR system, allowed expenditures for the period April 1, 1999 through December 31, 1999 (determined by applying the FY 2000 SGR to allowed expenditures for the 12-month period ending March 31, 1999) are subject to change based on revision of the FY 2000 SGR; allowed expenditures for the period January 1, 1999 through March 31, 1999 (determined using the FY 1999 SGR) are not subject to revision.

In general, the BBRA requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, as added by section 211(b)(5) of the BBRA, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the initial estimate.

The requirement of revisions to the SGR based on later data means that we will estimate and publish an SGR for the upcoming year, the contemporaneous year, and the preceding year by no later than November 1 of each year. For example, by no later than November 1, 2002, we will publish an estimate of the SGR for CY 2003, a revision of the CY 2002 SGR that is first being estimated in this notice, and a revision of the CY 2001 SGR first estimated in the final rule published on November 2, 2000 (65 FR 65429) and revised in this final rule. Under section 1848(f)(3)(C)(ii) of the Act, the final revision to the CY 2001 SGR will be announced in the **Federal Register** no later than November 1, 2002.

Subparagraphs (A) and (B) of section 1848(f)(3) of the Act, specify special rules with respect to the SGR and the CY 2001 and CY 2002 updates. Section 1848(f)(3)(A) of the Act required us, no later than November 1, 2000, to revise the SGRs for FY 2000 and CY 2000 and to establish the SGR for CY 2001, based on the best data available, as of September 1, 2000. We published our first estimate of the SGRs for FY 2000 and CY 2000 in a **Federal Register** notice on April 10, 2000 (65 FR 19000). Revised estimates of the SGRs for FY 2000 and CY 2000 and our original estimate of the SGR for CY 2001 appeared in the **Federal Register** on November 1, 2000 (65 FR 65429). We used each of the SGRs published in the November 1, 2000 **Federal Register** to determine the physician fee schedule update for 2001. Section 1848(f)(3)(B) of the Act requires us, by no later than November 1, 2001, to revise the SGRs for FY 2000 and CYs 2000 and 2001 and establish the SGR for CY 2002, based on the best data available as of September 1, 2001 and to use each of these SGRs to determine the physician fee schedule update for 2002. We are using each of the SGRs established in this notice to determine the 2002 physician fee schedule update. In accordance with section 1848(f)(3)(C)(ii) of the Act, there will be no further revisions to the FY 2000 and CY 2000 SGRs after the revisions we are making in this final rule.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services

covered by the SGR. The statute indicates that the term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee. The BBA and BBRA made no changes to this definition which was also used for the MVPS. We published a definition of physicians' services for use in the MVPS and subsequent SGR in the **Federal Register** (61 FR 59717) on November 22, 1996. We defined ''physicians' services'' to include many of the medical and other health services listed in section 1861(s) of the Act. Since the statute has made a number of changes to the definition of medical and other health services included in section 1861(s), we are updating our definition of physicians' services consistent with the statutory changes. Our practice has been to make adjustments to the SGR for medical and other health services added to the statute that meet the criterion of being ''commonly performed by a physician or a physicians' office.'' For instance, the BBA and the BIPA amended section 1861(s) of the Act to add new preventive benefits to the Medicare statute. Since these preventive services are generally provided by physicians or in physicians' offices, we made adjustments to the SGR to reflect additional Medicare expenditures for the newly-added Medicare benefits. Physicians' services for the SGR include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers:

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient physical therapy services and outpatient occupational therapy services.
- Antigens prepared by or under the direct supervision of a physician.
- Services of physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, glaucoma.
- Screening mammography, screening pap smears and screening pelvic exams.
- Diabetes outpatient self-management training services.
- Medical nutrition therapy services.
- Diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests.
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.

C. Provisions Related to the SGR

Section 211(b)(1) of the BBRA amends section 1848(f)(1) of the Act to require that SGR estimates be published in the **Federal Register** not later than November 1 of every year. In this notice, we are publishing our initial estimate of the SGR for 2002, a revised estimate of the SGR for 2001 and final estimates of the SGRs for FY and CY 2000.

In general, the update for a year is based on the Medicare Economic Index (MEI) as adjusted, within bounds, by the amount of actual expenditures for physicians' services compared to target (referred to as ''allowed'' in the statute) expenditures. A key difference between the MVPS and the SGR is that the comparison of actual and allowed expenditures is made on a cumulative basis under the SGR, while it was made on an annual basis under the MVPS. The ''update adjustment factor'' in section 1848(d)(4)(B) of the Act is an adjustment to the MEI that reflects the difference between actual expenditures and target expenditures.

Section 1848(d)(3)(C) of the Act, as modified by the BBA, defines allowed expenditures for the 12-month period ending March 31, 1997 to be equal to actual expenditures for physicians' services during that period (that is, April 1, 1996 through March 31, 1997), as we have estimated. Section 1848(d)(3)(C) of the Act defines allowed expenditures for subsequent 12-month periods to be equal to allowed expenditures for physicians' services for the previous year increased by the SGR for the FY which begins during the 12-month period. For example, allowed expenditures for the 12-month period April 1, 1997 through March 31, 1998 are equal to allowed expenditures for the 12 months ending March 31, 1997, increased by the SGR for FY 1998. The BBRA subsequently provided for a transition to a calendar year SGR system in 1999. Allowed expenditures for the first quarter of 1999 are determined using the FY 1999 SGR and allowed expenditures for the April 1, 1999 to December 31, 1999 period are determined using the FY 2000 SGR. Allowed expenditures in 2000 are equal to 1999 allowed expenditures increased by the 2000 SGR. Allowed expenditures for each subsequent year will equal expenditures from the prior year updated by the SGR.

Table 10 shows annual and cumulative allowed expenditures for physicians' services for each of the 12-month periods between April 1, 1996 and March 31, 2000, for 1999 and 2000.

TABLE 10

Period	Annual allowed expenditures (in billions)	Cumulative allowed expenditures (in billions)	FY or CY SGR
4/1/96–3/31/97	$48.9	$48.9	N/A
4/1/97–3/31/98	49.6	98.5	FY 1998=1.5%
4/1/98–3/31/99	49.4	47.9	FY 1998=−0.3%
1/1/99–3/31/99	12.5	[1]	FY 1999=−0.3%
4/1/99–12/31/99	39.6	[2]	FY 2000=6.9%
1/1/99–12/31/99	52.1	187.6	FY 1999/FY 2000
1/1/00–12/31/00	55.9	243.5	CY 2000=7.3%
1/1/01–12/31/01	59.3	302.7	CY 2001=6.1%
1/1/02–12/31/02	62.6	365.3	CY 2002=5.6%

[1] Included in $147.9 above.
[2] Included in $187.6 below.

Note: Allowed Expenditures for the first quarter of 1999 are based on the FY 1999 SGR and allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

Allowed Expenditures in the First Year

(April 1, 1996–March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on the CMS website under the Medicare Actuary's publications at the following address: *http://www.hcfa.gov/pubforms/actuary/.* We expect to update this information in November.

Allowed expenditures for the April 1, 1999 through the December 31, 1999 period are based on the FY 2000 SGR. As previously discussed, section 1848(f)(3) of the Act requires two revisions to the FY and CY 2000 SGR. We made the first revision to the FY and CY 2000 SGR in the physician fee schedule final rule published in the **Federal Register** on November 1, 2000 (65 FR 65427). We are making the second and final revision in this final rule. Consistent with section 1848(f)(3)(B) of the Act, the revised FY and CY 2000 SGR uses the best data available to us as of September 1, 2001.

D. Preliminary Estimate of the SGR for 2002

According to subparagraphs (A) through (D) of section 1848(f)(2) of the Act, as amended by section 211(b) of the BBRA, we have determined the preliminary estimate of the CY 2002 SGR to be 5.6 percent. We first estimated the CY 2002 SGR in March and made the estimate available to the Medicare Payment Advisory Commission and our website. Our March and current estimates of the four statutory factors are indicated in table 11:

TABLE 11

Statutory factors	March estimate	Current estimate
Fees	1.6	2.3
Enrollment	0.4	0.7
Real Per Capita GDP	2.4	1.7
Law and Regulation	1.5	0.8
Total	6.0	5.6

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, $1.023 \times 1.007 \times 1.017 \times 1.008 = 1.056$.) A more detailed explanation of each figure is provided below in section H.1.

E. Sustainable Growth Rate for CY 2001

According to subparagraphs (A) through (D) of section 1848(f)(2) of the Act, as amended by section 211(b) of the BBRA, our current estimate of the CY 2001 SGR is 6.1 percent. Table 12 shows our original estimate of the CY 2001 SGR published in the **Federal Register** on November 1, 2000 (65 FR 65433) and current estimates of the four statutory factors that determine the CY 2001 SGR:

TABLE 12

Statutory factors	11/1/00 estimate	Current estimate
Fees	1.9	1.9
Enrollment	0.9	3.0
Real Per Capita GDP	2.7	0.7
Law and Regulation	0.0	0.4
Total	5.6	6.1

A more detailed explanation of each figure is provided below in section H.2.

F. Sustainable Growth Rate for CY 2000

According to subparagraphs (A) through (D) of section 1848(f)(2) of the Act, as amended by section 211(b) of the BBRA, our current estimate of the CY 2000 SGR is 7.3 percent. Table 13 shows estimates included in the November 1, 2000 **Federal Register** (65 FR 65433) and current estimates of the four statutory factors that determine the CY 2000 SGR:

TABLE 13

Statutory factors	11/1/00 estimate	Current estimate
Fees	2.1	2.1
Enrollment	1.0	1.0
Real Per Capita GDP	4.3	3.2
Law and Regulation	0.5	0.8
Total	8.1	7.3

A more detailed explanation of each figure is provided below in section H.3.

G. Sustainable Growth Rate for FY 2000

According to subparagraphs (A) through (D) of section 1848(f)(2) of the Act, as amended by section 211(b) of the BBRA, our current estimate of the FY 2000 SGR is 6.9 percent. Table 14 shows estimates included in the November 1, 2000 **Federal Register** (65 FR 65433) and current estimates of the four statutory factors that determine the FY 2000 SGR:

TABLE 14

Statutory factors	11/1/00 estimate	Current estimate
Fees	2.1	2.1
Enrollment	0.8	0.5
Real Per Capita GDP	4.5	3.6
Law and Regulation	0.3	0.6
Total	7.9	6.9

A more detailed explanation of each figure is provided below in section H.3.

H. Calculation of the FY 2000, CY 2000, CY 2001, and CY 2002 Sustainable Growth Rates

1. Detail on the CY 2002 SGR

A more detailed discussion of our preliminary estimates of the four elements of the 2002 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2002

This factor was calculated as a weighted average of the CY 2002 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

Physicians' services as defined in sections 1861(s)(1) and (2) of the Act represent approximately 89 percent of allowed charges for physicians' services under the SGR and are updated by the Medicare Economic Index (MEI). Our current estimate of the MEI for 2002 is 2.6 percent. Diagnostic laboratory tests represent approximately 11 percent of the Medicare allowed charges for physicians' services under the SGR. The BBA provided for a 0.0 percent update for CY 2002 for laboratory services. Table 15 shows both the physicians' and laboratory service updates that were used to determine the percentage increase in physicians' fees for CY 2002.

TABLE 15

	Weight	Update
Physician	0.89	2.6
Laboratory	0.11	0.0
Weighted Average	1.0	2.3

After taking into account the elements described in the table, we estimate that the weighted-average increase in fees for CY 2002 for physicians' services under the SGR (before applying any legislative adjustments) will be 2.3 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From CY 2001 to CY 2002

This factor is our estimate of the percent change in the average number of

fee-for-service enrollees for CY 2002 as compared to CY 2001 Medicare+Choice (M+C) plan enrollees, whose Medicare-covered medical care is outside the scope of the SGR, and who are excluded from this estimate. Our actuaries estimate that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) will increase by 0.7 percent in calendar year 2002. This estimate was derived by subtracting estimated M+C enrollment from estimated overall Medicare enrollment as illustrated in table 16.

TABLE 16

[In millions]

	2001	2002
Overall	37.828	38.149
Medicare+Choice	5.662	5.761
Net	32.166	32.388
Percent Increase:		0.7

Since 2002 has yet to begin, we currently only have estimates of this figure for 2002. An important factor affecting fee-for-service enrollment is beneficiary enrollment in Medicare+Choice plans. At this time, we do not know how actual enrollment in Medicare+Choice plans will compare to current estimates. While we do receive information on whether a Medicare+Choice plan will continue to participate or withdraw from the program, it remains difficult to estimate the number of beneficiaries who will select a Medicare+Choice plan or fee-for-service before the start of the calendar year. While some plans will no longer offer a Medicare+Choice plan, other plans are available as an option to most beneficiaries in areas where there have been plan withdrawals. It is difficult to estimate the size of the Medicare+Choice enrollee population before the start of a calendar year. Because we determine the fee-for-service enrollment figure net of the change in Medicare+Choice enrollment, early estimates of this factor are difficult to make. Our estimate of this factor is preliminary and only has minimal effect on the physician fee schedule update for CY 2002. The CY 2002 SGR will also be used in the calculation of the 2003 physician fee schedule update in a final rule to be published no later than November 1, 2002. By that time, we will have information on actual enrollment in Medicare+Choice plans for the first 8 months of CY 2002 and will be better able to predict the change in fee-for-service enrollment for the year.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in CY 2002

Section 1848(f)(2)(C) of the Act, as amended by section 211 of the BBRA, requires us to estimate growth in real GDP per capita. This factor is applied on a CY basis beginning with the CY 2000 SGR. We estimate that the growth in real per capita GDP will be 1.7 percent in CY 2002. Our past experience indicates that there have also been large changes in estimates of real per capita GDP growth and the actual change in this factor. It is likely that this figure will change further as actual information on economic performance becomes available to us in 2002. Again, we note that we will use revised estimates of real per capita GDP growth in setting future year updates.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in CY 2002 Compared With CY 2001

Sections 101 through 104 of BIPA added Medicare coverage for screening glaucoma, authorized Medicare to pay for specific new technology mammography services, and changed coverage for screening pap smears, screening pelvic exams, and screening colonoscopy for average-risk individuals. In addition, section 105 of the BIPA also establishes a new benefit for medical nutrition therapy and expands access to telehealth services in section 223. Section 432 of the BIPA also requires that Medicare make payment to Indian Health Service hospitals and ambulatory clinics for physicians' and practitioners' services as well as outpatient physical and occupational therapy services that are included in the definition of physicians' services for purposes of the SGR. Since these provisions will increase Medicare expenditures for services that are included in the SGR, we are making an upward adjustment to reflect additional Medicare expenditures in 2002. Our estimates of the cost of these provisions for the period FY 2002–FY 2006 are included in our Notice of Proposed Rulemaking published in the **Federal Register** on August 2, 2001 (66 FR 40400).

We are making an adjustment to the SGR for one additional factor. In section VI.B. of this final rule, we provided a definition of physicians' services for purposes of the SGR. Historically, we have not measured expenditures for screening mammography under the SGR. However, section 1848(f)(4) of the Act indicates that ''physicians'' services includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office.'' Screening mammography services are ''radiology services'' that are performed by ''physicians or in a physician's office.'' As a result, we are using this rule to add screening mammography to the list of services that are part of the SGR definition. Since we have not previously measured expenditures for screening mammography services under the SGR, it is appropriate to make an adjustment to this factor for the change to the definition of physicians' services. We are making an adjustment that reflects estimated payments for screening mammography services in CY 2002. We will make a subsequent revision based on actual expenditures for screening mammography.

After taking these provisions into account, the percentage change in expenditures for physicians' services resulting from changes in law or regulations is estimated to be 0.8 percent for 2002. In March, we estimated that this figure would be 1.5 percent. The 0.7 percentage point difference is due to a change in our estimate of the BIPA provisions. In March, we had no information about implementation of these provisions. We used updated assumptions about pricing and utilization based on proposed policies published in the August 2, 2001 proposed rule (66 FR 40400).

2. Detail on the CY 2001 SGR

A more detailed discussion of our current estimates of the four elements of the 2001 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2001

We are continuing to use 1.9 percent for this element of the SGR for the CY 2001 SGR. This factor is unchanged from earlier estimates previously described for CY 2001 in the November 1, 2000 **Federal Register** (65 FR 65433).

Factor 2—The Percentage Change in the Average Number of Fee-for-Service Part B Enrollees From CY 2000 to CY 2001

This factor is our estimate of the percent change in the average number of fee-for-service enrollees for CY 2001 as compared to CY 2000. As we indicated above, this factor is difficult to estimate prior to the beginning of the period for which the estimates are being made because of the interaction of the fee-for-service and Medicare+Choice program and the lack of availability of actual data

on beneficiary selection of Medicare+Choice enrollment. We currently have information on actual enrollment in the Medicare+Choice program for CY 2001 and CY 2000 that permits estimates of the change in fee-for-service enrollment for these years that will be more reflective of the final actual enrollment and percent year-to-year change. The estimates for CY 2000 and CY 2001 were derived by subtracting estimated M+C enrollment from estimated overall Medicare enrollment as illustrated in table 17.

TABLE 17
[In millions]

	2000	2001
Overall	37.453	37.828
Medicare+Choice	6.233	5.662
Net	31.221	32.166
Percent Increase		3.0

Our actuaries estimate of the percent change in the average number of fee-for-service enrollees net of Medicare+Choice enrollment for 2001 compared to 2000 of 3.0 percent is more than our early estimate of this factor (0.9 percent for CY 2001 from the November 1, 2000 **Federal Register** (65 FR 65433)) because the historical base from which our actuarial estimate is made has changed. We currently have complete information on Medicare fee-for-service enrollment for 2000 that is lower than the figure we used one year ago. Further, we now have information on actual fee-for-service enrollment for the first 8 months of 2001. This figure is slightly higher than the figure used in the November 1, 2000 **Federal Register** (65 FR 65433). We would caution that our estimate of fee-for-service enrollment for 2001 may change once we have complete information for the entire year.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in CY 2001

Section 1848(f)(2)(C) of the Act, as amended by section 211 of the BBRA, requires us to estimate growth in real GDP per capita. We estimate that the growth in real per capita GDP will be 0.7 percent in CY 2001. There have also been large changes in initial estimates of real per capita GDP growth and the actual change in this factor. There could be further changes in this factor once we have complete information on economic performance for the entire year. Again, we note that we will use revised estimates of real per capita GDP growth in setting future year updates.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in CY 2001 Compared With CY 2000

As described above, the BIPA makes changes to the Act that affect Medicare expenditures for services that are included in the SGR. Some of these provisions have no effect on Medicare expenditures in 2001 because they do not go into effect until 2002. Other provisions are effective at some time during 2001. Provisions that become effective in 2001 relate to new technology mammography and coverage changes for screening pap smears, screening pelvic exams and screening colonoscopy, expanded access to telehealth services and Medicare payment for services provided in Indian Health Service hospitals and clinics. After taking these provisions into account, the percentage change in expenditures for physicians' services resulting from changes in law or regulations is estimated to be 0.4 percent for 2001.

3. Detail on Calculation of the FY 2000 and CY 2000 SGRs

A more detailed discussion of our revised estimates of the four elements of the FY 2000 and CY 2000 SGRs follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for FY 2000 SGR and CY 2000 SGR

We are continuing to use 2.1 percent for this element of the SGR for the FY 2000 SGR and the CY 2000 SGR. This factor is unchanged from earlier estimates previously described respectively for FY 2000 and CY 2000 in the October 1, 1999 **Federal Register** (64 FR 53395), the April 10, 2000 **Federal Register** (65 FR 19003) and the August 2, 2001 **Federal Register** (66 FR 40397).

Factor 2—The Percentage Change in the Average Number of Fee-for-Service Part B Enrollees for the FY 2000 SGR and CY 2000 SGR

This factor is our estimate of the percent change in the average number of fee-for-service enrollees for FY 2000 as compared to FY 1999 and CY 2000 as compared to CY 1999. We currently have complete information on actual enrollment in the Medicare+Choice program for FY 2000 and CY 2000 that permits a measure of change in fee-for-service enrollment for these years that reflects the actual change. The estimates for CY 2000 were derived by subtracting estimated M+C enrollment from estimated overall Medicare enrollment as illustrated in table 18.

TABLE 18
[In millions]

	1999	2000
Overall	37.115	37.453
Medicare+Choice	6.191	6.233
Net	30.923	31.221
Percent Increase		1.0

Our actuaries' estimate of the percent change in the average number of fee-for-service enrollees net of Medicare+Choice enrollment for 2000 compared to 1999 of 1.0 percent is the same as our estimate of this factor at this time last year (1.0 percent). However, the current estimate of 0.5 percent for FY 2000 is lower than the 0.8 percent estimate of this factor at this time last year.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in FY 2000 and CY 2000

We estimate that real GDP per capita growth will be 3.6 percent for FY 2000 and 3.2 percent for CY 2000. In the FY 2000 SGR notice published on October 1, 1999 (64 FR 53396), we estimated that real GDP per capita growth for FY 2000 would be 1.8 percent. In our April 10, 2000 SGR notice, we estimated that real GDP per capita growth for CY 2000 would be 2.5 percent. In our November 1, 2000 final rule (65 FR 65433), we estimated that real GDP per capita growth would be 4.5 percent for FY 2000 and 4.3 percent CY 2000. The final figures that we will use for this factor are 3.6 percent for FY 2000 and 3.2 percent for CY 2000. The latest figures on real GDP per capita growth are approximately one percentage point less than estimated last year. The lower estimates are due to annual revisions of the National Income and Product Accounts (NIPA) by the Bureau of Economic Analysis. Usually, in annual revisions of the NIPA, new estimates incorporate source data that are more complete, more detailed, and otherwise more appropriate than those that were previously incorporated. In addition, several methodological changes have been made. (For detailed description of the NIPA revisions, see Brent R. Moulton, Eugene P. Seskin, and David F. Sullivan, ''Annual Revision of the National Income and Product Accounts: Annual Estimates, 1998–2000, Quarterly Estimates, 1998: 1–2000: I, Survey of Current Business'' (August, 2001): 7–32.)

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in FY 2000 Compared with FY 1999, and CY 2000, Compared With CY 1999

As we explained in our October 1, 1999 and April 10, 2000 SGR notices, legislative changes contained in the BBA and the BBRA will have an impact on expenditures for physicians' services under the SGR in FY 2000 and CY 2000. Section 4103 of the BBA mandates a new prostate screening benefit effective January 1, 2000. Additionally, effective January 1, 2000, section 4513 of the BBA removes the requirement that a subluxation of the spine be demonstrated by an x-ray before Medicare payment can be made for chiropractic services furnished to a beneficiary. This provision will also result in a small increase in expenditures in FY 2000 and CY 2000. The impact of BBA Medicare Secondary Payer provisions will have small marginal impact on reducing expenditures in FY 2000 and CY 2000.

Certain BBRA provisions also have a small impact on expenditures in FY 2000 and CY 2000. Section 224 of the BBRA increases payments for pap smears and is slightly increasing expenditures. Section 221 of the BBRA postponed the implementation of payment caps on physical and occupational therapy and speech-language pathology services. The effect of this provision on physicians and independent practitioners is a small increase in expenditures for these years. Medicare expenditures for outpatient physical and occupational therapy services by therapists in independent practice are growing rapidly as a result of provisions of section 4541 of the BBA that require Medicare to make payments for facility-based therapy services under the physician fee schedule. Physical and occupational therapy services previously paid on the basis of a cost report through the Medicare fiscal intermediaries are more likely to be billed by therapists in independent practice because these services are no longer being paid on a cost basis. We analyzed growth in Medicare expenditures for physical and occupational therapy and believe that the larger rate of increase in Medicare expenditures for these services billed to carriers is likely a result of the statutory provisions that require the services to be paid under the Medicare physician fee schedule. We are making an upward adjustment to the SGR for this factor.

After taking into account these provisions, the percentage change in expenditures for physicians' services resulting from changes in law or regulations is estimated to be 0.6 percent for FY 2000 and 0.8 percent for CY 2000.

IX. Calculation of the 2002 Physician Fee Schedule and Anesthesia Conversion Factor

The 2002 physician fee schedule conversion factor is $36.1992. The separate 2002 national average anesthesia conversion factor is $16.60.

The specific calculations to determine the physician fee schedule and anesthesia conversion factor for calendar year 2002 are explained below.

Detail on Calculation of the Calendar Year 2002 Physician Fee Schedule Conversion Factor

• Physician Fee Schedule Conversion Factor

Under section 1848(d)(1)(A) of the Act, the physician fee schedule conversion factor is equal to the conversion factor for the previous year multiplied by the update determined under section 1848(d)(4) of the Act. In addition, section 1848(c)(2)(B)(ii)(II) of the Act requires that changes to relative value units (RVUs) cannot cause expenditures to increase or decrease by more than $20 million from the amount of expenditures that would have been made if such adjustments had not been made. We implement this requirement through a uniform budget neutrality adjustment to the conversion factor. There are two changes that will require us to make an adjustment to the conversion factor to comply with the budget neutrality requirement in section 1848(c)(2)(B)(ii)(II) of the Act. We are making a 0.460 percent reduction (0.9954) in the conversion factor to account for the increase in work RVUs resulting from the 5-year review. We are also making a 0.18 percent (0.9982) reduction in the conversion factor to account for an anticipated increase in the volume and intensity of services in response to the final year of the implementation of resource-based practice expense RVUs. As a result of the 5-year review of RVUs and additional budget-neutrality adjustments required by law, the conversion factor is 5.4 percent lower than last year's conversion factor.

The two budget neutrality factors are applied after the update is applied to the 2001 conversion factor:

TABLE 19

2001	Conversion Factor	$38.2581
2002	Update	0.9523
	Budget-Neutrality Adjustment: 5 Year Review	0.9954
	Budget-Neutrality Adjustment: Practice Expense Transition	0.9982
2002	Conversion Factor	$36.1992

• Anesthesia Fee Schedule Conversion Factor

Section 1848(b)(2)(B) of the Act indicates that, to the extent practicable, the Secretary will use the anesthesia relative value guide with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services. The statute also requires the Secretary to adjust the conversion factor by geographic adjustment factors in the same manner as for other physician fee schedule services. Unlike other physician fee schedule services, anesthesia services are paid using a system of base and time units. The base and time units are summed and multiplied by a conversion factor. The base unit is fixed depending upon the type of anesthesia procedure performed, and the time units will vary based on the length of the anesthesia time associated with the surgical procedure. Thus, Medicare's payment will increase as anesthesia time lengthens. The same anesthesia service provided in two different surgeries will be paid different amounts if the associated anesthesia time is different. This system differs from other physician fee schedule services where payment is determined based on the product of RVUs and a conversion factor; payment for a given procedure will not vary based on the length of time it takes to perform the procedure in a specific instance.

Since anesthesia services do not have RVUs like other physician fee schedule services, we have had to make appropriate adjustments to the anesthesia fee schedule conversion factor to simulate changes to RVUs. We modeled the resource-based practice expense methodology using imputed anesthesia RVUs that were made comparable to other physician fee schedule services. As a result of modeling these changes, we are incorporating a 1.89 percent reduction (0.9811) to the anesthesia fee schedule conversion factor. We are incorporating an additional increase of 0.2 percent (1.002) to account for base unit revisions for 2002, both for the five-year review and for the alignment of CMS base units with ASA base units. All other adjustments (physician fee schedule update, adjustment for 5-year review of

physician work, adjustment for volume and intensity changes) made to the anesthesia fee schedule conversion factor are the same as those applied to the physician fee schedule. To determine the anesthesia fee schedule conversion factor for 2002, we used the following figures:

TABLE 20

2001 Anesthesia Conversion Factor	$17.83
2002 Update	0.9523
Practice Expense RVU Adjustment for 2002	0.9823
Adjustment for Base Unit Alignment	1.0020
5-Year Review	0.9954
Volume and Intensity Adjustment	0.9982
2003 Conversion Factor	$16.60

X. Provisions of the Final Rule

The provisions of this final rule restate the provisions of the August 2001 proposed rule, except as noted elsewhere in the preamble. Following is a highlight of the changes made from the proposed rule:

For screening glaucoma, we are revising the regulation in § 410.23(a)(2) to read ''Eligible beneficiary means individuals in the following high risk categories.'' This should allow us to more easily add high-risk groups by rulemaking should the medical evidence warrant it.

For G0117 Glaucoma Screening for High Risk Patients Furnished by an Optometrist or Ophthalmologist, we will assign 0.45 work RVUs, .02 malpractice RVUs, and we will crosswalk practice expense inputs from CPT code 92012.

For G0118 Glaucoma Screening for High Risk Patients Furnished Under the Direct Supervision of an Optometrist or Ophthalmologist, we will assign 0.17 work RVUs and 0.01 malpractice RVUs. For practice expense, we will also crosswalk this code to CPT code 92012.

For medical nutrition therapy, we made various changes in response to comments received. For detailed information, see section III.G.

For telehealth services section 1834(m)(3) of the Act specifies that sections 1842(b)(18)(A) and (B) apply to physicians and practitioners receiving payment for telehealth services and to originating sites receiving a facility fee, in the same manner as they apply to practitioners. This section requires that payment for these services may only be made on an assignment-related basis. We did not reflect this provision in the proposed rule. Nonetheless, because this requirement is required by the plain language of the law and because we are without discretion with respect to its application, we are implementing it in this final rule in new § 414.65(d).

Other Issues

Included in the comments we received were issues and topics that were not specifically included as proposals in the August 2, 2001 proposed rule such as coding issues on specific services, the need to expand dissemination of information on Medicare benefits and a variety of other topics. While we do not address these specifically in this rule, we will ensure that the appropriate CMS components are aware of the concerns expressed and would hope that these concerns can be addressed through appropriate channels.

XI. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for § 410.132 in this document, which contains information collection requirements.

Paragraph (c) of this section requires a referring physician or practitioner to maintain referral documentation in the beneficiary's medical record for each referral.

We believe the burden associated with these provisions is exempt in accordance with 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with these requirements would be incurred by referring physicians and practitioners in the normal course of business activities.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Information Services, Information Technology Investment Management Group, Attn.: John Burke, CMS–1169–FC, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, CMS Desk Officer.

XII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XIII. Regulatory Impact Analysis

We have examined the impact of this final rule as required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4), the Regulatory Flexibility Act of 1980 (RFA) (Pub. L. 96–354), and Executive Order 13132 of August 4, 1999 (Federalism).

EO 12866 directs agencies to assess costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). While the changes in the Medicare physician fee schedule are, for the most part, budget neutral, they do involve redistribution of Medicare spending among procedures and physician specialties. The redistributive effect of this rule on any particular specialty is in our estimate likely to exceed $100 million for at least one specialty group. For this reason we are considering this a major economic rule.

However, it is important to note, as indicated in section VII of this preamble, the physician fee update for 2002 under section 1848(d) of the Act is −4.8 percent of an estimated $41.2 billion in physician expenditures for 2001. Even though the physician fee schedule update is −4.8 percent, we project that the total Medicare

expenditures for physicians' services will increase from $41.2 billion to $41.7 billion in 2002.

The UMRA also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million or more. We have determined that this rule has no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below the above-stated threshold as well.

The RFA requires that we analyze regulatory options for small businesses and other small entities. We prepare a Regulatory Flexibility Analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives and lessen significant adverse economic impact on the small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

For purposes of the RFA, all physicians are considered to be small entities. There are about 700,000 physicians and other practitioners who receive Medicare payment under the physician fee schedule.

For the purpose of EO 12866 and the RFA we have prepared the following analysis, which, together with the rest of this preamble, meets all four assessment requirements. It explains the rationale for and purpose of the rule, details the costs and benefits of the rule, analyzes alternatives, and presents the measures we considered to minimize the burden on small entities.

A. 5 Year Review of Physician Work and Resource-Based Practice Expense Relative Value Units

Revisions in physician work and resource-based practice expense RVUs for physicians' services are required by law to be budget neutral. We calculate total payments from the revisions to work and practice expense relative value units such that total payments do not change more than $20 million as a result of the revisions. Increases in payments for some services are necessarily offset by decreases in payments for other services. For revisions to physician work values that are occuring as part of the 5-year review, we are making a budget neutrality adjustment to the physician fee schedule conversion factor. For practice expense, we adjust all the practice expense RVUs upwards or downwards to meet the budget neutrality requirement in the statute. This means that increases in practice expense RVUs for some services will be offset by corresponding decreases in values for other services. We showed the impact of proposed changes in physician work and practice expense RVUs in our Notice of Proposed Rulemaking in the **Federal Register** on August 2, 2001 (65 FR 40397). Table 21 shows the impact on total allowed charges by specialty of this final rule's physician work and practice expense RVU changes. We are showing the impact of the proposed rule changes as well additional changes that are occurring as a result of this final rule. There are five changes we are adopting in this final rule that result in changes to the impacts displayed in the proposed rule. Table 21 incorporates additional impacts that result from using 2000 utilization data to determine the resource-based practice expense RVUs. This change has a very modest effect on payment for nearly all specialties. Based on public comments to our notice of proposed rulemaking, we have also made changes to physician work RVUs that were part of the 5-year review. These changes will increase payments to Gastronterology, General Surgery, Obstetrics and Gynecology and Podiatry. We also incorporated revised physician time data supplied to us by the Relative Value Update Committee (RUC). Relative to the physician times used in our proposed rule, there were slight refinements to some codes. With the exception of Nephrology, the new times have virtually no impact on specialty level payments. Nephrology payments will go up as a result of using new physician times supplied to us by the RUC. The RUC supplied us with a time of 186 minutes for the highest volume nephrology procedure code, 90921. This compared to a physician time of 153 minutes that was previously used. Finally, we also incorporated refinements to the practice expense inputs that are being recommended by the Practice Expense Advisory Committee (PEAC) and the RUC. These changes will result in a reduction in average payments to rheumatology of about 6 percent. This occurs primarily as a result of refinements to 4 codes that are frequently performed by rheumatologists (20610, 20550, 20605 and 20600). Based on the PEAC and RUC comments, we made changes to the practice expense inputs that result in a reduction in relative payments for these procedure codes. Other specialties that will experience a smaller reduction in payments as a result of the practice expense refinements for 2002 are Orthopedic Surgery, Podiatry and Urology. Since the changes are budget neutral, the reductions in practice expense RVUs will be offset by increases in practice expense payments that will be broadly distributed among other physician specialties.

Table 21 shows the impact of this final rule compared to the proposed rule that was published on August 2, 2001. We note that the table shows the impact of this rule only and does not incorporate practice expense changes from three other final rules, November 2, 1998 (63 FR 58895), November 2, 1999 (64 FR 59433) and November 1, 2000 (65 FR 65377). The table shows the average specialty change in payments in CY 2002 that are occurring as a result of this final rule relative to what would have occurred in 2002 had this rule not been published. The rule shows the redistributive (or relative) change in payments among specialties. It does not show the absolute average change in specialty level payments from 2001 to 2002 that are also affected by the final year of the transition to resource-based practice expense RVUs and the physician fee schedule update. The transition to resource-based RVUs is complete in CY 2002 and has no effect when comparing the impact on CY 2002 payments before and after changes made in this final rule. The physician fee schedule update and change to the conversion factor are discussed in sections VII and IX, respectively.

TABLE 21.—IMPACT OF PHYSICIAN WORK AND PRACTICE EXPENSE RELATIVE VALUE UNIT CHANGES—FINAL RULE COMPARED TO PROPOSED RULE

Specialty	Allowed charges (billions)	Proposed rule impact (percent)	Final rule impact (percent)
Anesthesiology	$1.5	1	1
Cardiac Surgery	0.3	0	0
Cardiology	4.2	0	−1
Chiropractor	0.4	0	0
Clinics	1.6	0	0
Dermatology	1.4	1	2
Emergency Medicine	1.0	0	0
Family Practice	3.3	0	0
Gastroenterology	1.2	1	3
General Practice	1.0	0	0
General Surgery	2.0	4	4
Hematology Oncology	0.6	0	1
Internal Medicine	7.1	0	1
Nephrology	1.0	0	2
Neurology	0.9	0	0
Neurosurgery	0.4	0	0
Nonphysician Practitioner	1.2	0	1
Obstetrics/Gynecology	0.4	1	2
Ophthalmology	3.9	–1	–1
Optometrist	0.5	0	–3
Orthopedic Surgery	2.3	0	–1
Other Physician	1.4	1	0
Otolaryngology	0.6	0	1
Pathology	0.6	3	3
Plastic Surgery	0.2	0	1
Podiatry	1.1	1	0
Psychiatry	1.1	0	0
Pulmonary	1.1	0	1
Radiation Oncology	0.7	0	−2
Radiology	3.3	0	−1
Rheumatology	0.3	0	−6
Suppliers	0.7	2	0
Thoracic Surgery	0.5	1	0
Urology	1.3	1	1
Vascular Surgery	0.3	2	1

Table 22, titled Impact of 5-Year Review and Proposed Rule on Medicare Payments for Selected Procedures, shows the percentage change in total payment (in CY 2002 physician fee schedule dollars) for selected high-volume procedures that result from changes to the physician work, practice expense and malpractice announced in this final rule. These tables reflect the impact of this final rule only on the fully implemented fee schedule amount. The payments in these columns are determined using a conversion factor $36.1992. The RVUs used for calculating payment in the ''old'' columns are from the November 1, 2000 final rule. The RVUs used in calculating payments in the ''new'' columns are from this final rule. By using the same conversion factor of $36.1992 to calculate payments in both the ''old'' and ''new'' columns, the impact of changes to the RVUs that are included in this final rule are illustrated. These tables do not show the actual impact on payment from 2001 to 2002 that are also affected by the final year of the practice expense transition and physician fee schedule update.

TABLE 22.—IMPACT OF 5 YEAR REVIEW AND PROPOSED RULE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES

HCPCS	MOD	DESC	Old non-facility	New non-facility	Percent change	Old facility	New facility	Percent change
11721		Debride nail, 6 or more	$40.18	$36.92	−8	$28.96	$28.96	0
17000		Destroy benign/premal lesion	60.45	62.62	4	32.58	32.94	1
27130		Total hip replacement	NA	NA	NA	1,419.01	1,452.31	2
27236		Treat thigh fracture	NA	NA	NA	1,088.87	1,113.85	2
27244		Treat thigh fracture	NA	NA	NA	1,111.68	1,137.38	2
27447		Total knee replacement	NA	NA	NA	1,483.08	1,514.21	2
33533		CABG, arterial, single	NA	NA	NA	1,756.02	1,827.34	4
35301		Rechanneling of artery	NA	NA	NA	1,107.33	1,061.36	−4
43239		Upper GI endoscopy, biopsy	281.99	354.75	26	148.78	154.93	4
45385		Lesion removal colonoscopy	474.93	571.22	20	283.44	287.78	2
66821		After cataract laser surgery	217.56	229.50	6	203.44	213.94	5
66984		Cataract surg w/iol, i stage	NA	NA	NA	660.27	669.32	1
67210		Treatment of retinal lesion	594.03	603.08	2	544.44	546.61	0

TABLE 22.—IMPACT OF 5 YEAR REVIEW AND PROPOSED RULE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES—Continued

HCPCS	MOD	DESC	Old non-facility	New non-facility	Percent change	Old facility	New facility	Percent change
71010	26	Chest x-ray	9.05	9.05	0	9.05	9.05	0
71020	26	Chest x-ray	11.22	11.22	0	11.22	11.22	0
76091		Mammogram, both breasts	84.34	90.50	7	NA	NA	NA
76091	26	Mammogram, both breasts	35.11	43.44	24	35.11	43.44	24
76092		Mammogram, screening	71.03	80.72	14	71.03	80.72	14
76092	26	Mammogram, screening	22.73	35.48	56	22.73	35.48	56
77427		Radiation tx management, x5	167.24	167.96	0	167.24	167.96	0
78465	26	Heart image (3d), multiple	75.29	74.93	−1	75.29	74.93	−1
88305	26	Tissue exam by pathologist	39.82	40.54	2	39.82	40.54	2
90801		Psy dx interview	145.52	144.80	−1	137.19	137.19	0
90806		Psytx, off, 45–50 min	96.65	95.93	−1	91.22	91.22	0
90807		Psytx, off, 45-50 min w/e&m	103.89	103.53	0	98.82	98.82	0
90862		Medication management	51.04	51.04	0	46.33	46.33	0
90921		ESRD related services, month	263.89	273.30	4	263.89	273.30	4
90935		Hemodialysis, one evaluation	NA	NA	NA	73.48	76.38	4
92004		Eye exam, new patient	124.16	123.44	−1	87.60	87.96	0
92012		Eye exam established pat	62.62	61.18	−2	35.84	35.84	0
92014		Eye exam & treatment	89.77	91.22	2	59.00	58.64	−1
92980		Insert intracoronary stent	NA	NA	NA	799.64	790.59	−1
92982		Coronary artery dilation	NA	NA	NA	592.22	584.26	−1
93000		Electrocardiogram, complete	26.06	25.34	−3	NA	NA	NA
93010		Electrocardiogram report	9.05	9.05	0	9.05	9.05	0
93015		Cardiovascular stress test	102.81	99.91	−3	NA	NA	NA
93307	26	Echo exam of heart	48.51	48.14	−1	48.51	48.14	−1
93510	26	Left heart catheterization	232.76	230.59	−1	232.76	230.59	−1
98941		Chiropractic manipulation	35.48	35.48	0	30.77	31.13	1
99202		Office/outpatient visit, new	60.45	61.54	2	45.61	45.61	0
99203		Office/outpatient visit, new	90.50	91.95	2	69.50	69.50	0
99204		Office/outpatient visit, new	130.32	130.68	0	102.81	102.81	0
99205		Office/outpatient visit, new	165.07	166.15	1	136.11	136.47	0
99211		Office/outpatient visit, est	19.91	20.27	2	8.69	8.69	0
99212		Office/outpatient visit, est	35.48	36.20	2	23.17	23.17	0
99213		Office/outpatient visit, est	49.59	50.32	2	34.03	34.03	0
99214		Office/outpatient visit, est	78.19	78.91	1	55.75	56.11	1
99215		Office/outpatient visit, est	114.39	115.84	1	90.14	90.50	0
99221		Initial hospital care	NA	NA	NA	65.16	65.16	0
99222		Initial hospital care	NA	NA	NA	107.87	108.24	0
99223		Initial hospital care	NA	NA	NA	150.59	150.95	0
99231		Subsequent hospital care	NA	NA	NA	32.58	32.58	0
99232		Subsequent hospital care	NA	NA	NA	53.21	53.57	1
99233		Subsequent hospital care	NA	NA	NA	76.02	76.38	1
99236		Observ/hosp same date	NA	NA	NA	213.58	214.66	1
99238		Hospital discharge day	NA	NA	NA	64.07	66.24	3
99239		Hospital discharge day	NA	NA	NA	87.60	90.86	4
99241		Office consultation	46.33	47.06	2	32.94	33.30	1
99242		Office consultation	86.15	87.24	1	67.69	68.05	1
99243		Office consultation	114.39	115.84	1	90.14	90.14	0
99244		Office consultation	162.53	164.34	1	133.21	133.58	0
99245		Office consultation	211.04	212.85	1	176.65	177.01	0
99251		Initial inpatient consult	NA	NA	NA	36.20	34.75	−4
99252		Initial inpatient consult	NA	NA	NA	71.31	69.86	−2
99253		Initial inpatient consult	NA	NA	NA	96.65	95.20	−2
99254		Initial inpatient consult	NA	NA	NA	138.28	136.83	−1
99255		Initial inpatient consult	NA	NA	NA	189.68	188.60	−1
99261		Follow-up inpatient consult	NA	NA	NA	23.53	21.72	−8
99262		Follow-up inpatient consult	NA	NA	NA	45.25	43.44	−4
99263		Follow-up inpatient consult	NA	NA	NA	66.24	64.80	−2
99282		Emergency dept visit	NA	NA	NA	26.43	26.43	0
99283		Emergency dept visit	NA	NA	NA	59.37	59.37	0
99284		Emergency dept visit	NA	NA	NA	92.67	92.67	0
99285		Emergency dept visit	NA	NA	NA	144.43	144.80	0
99291		Critical care, first hour	NA	NA	NA	197.65	198.37	0
99292		Critical care, addl 30 min	NA	NA	NA	98.46	98.82	0
99301		Nursing facility care	60.09	70.23	17	60.09	60.09	0
99302		Nursing facility care	80.36	95.57	19	80.36	80.72	0
99303		Nursing facility care	99.91	118.73	19	99.91	100.27	0
99311		Nursing fac care, subseq	30.05	40.18	34	30.05	30.05	0
99312		Nursing fac care, subseq	49.59	61.90	25	49.59	49.95	1
99313		Nursing fac care, subseq	70.59	84.34	20	70.59	70.95	1

TABLE 22.—IMPACT OF 5 YEAR REVIEW AND PROPOSED RULE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES—Continued

HCPCS	MOD	DESC	Old non-facility	New non-facility	Percent change	Old facility	New facility	Percent change
99348	.....	Home visit, est patient	73.12	73.85	1	NA	NA	NA
99350	.....	Home visit, est patient	166.88	166.52	0	NA	NA	NA

(In two different places above, we indicate that the tables do not include the effect of the ''final'' year of the practice expense transition. While we note that resource-based practice expense will be fully implemented in 2002, our expectation is that we would continue to make refinements that improve the practice expense relative value units. We acknowledge that the efforts of the PEAC and RUC to make useful comments on practice expense inputs have resulted in significant improvements to the data we are using to determine practice expense relative value units. The refinements we have made to date have affected hundreds of procedure codes accounting for a high percentage of Medicare expenditures paid under the physician fee schedule. Our expectation is that this work will continue and we continue, to welcome comments and input from all members of the public interested in these issues).

B. Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists Performing Screening Sigmoidoscopies

As discussed in section II.B. of the preamble, this regulation will expand the list of practitioners for whose services Medicare may make payment for screening flexible sigmoidoscopies to include nurse practitioners, physician assistants, and clinical nurse specialists, as long as those practitioners meet applicable Medicare qualification requirements, and they are authorized to perform those screening services under State law. At present, the Medicare condition of coverage for screening flexible sigmoidoscopies limits coverage of those services to those that are performed by either a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act) who is authorized under State law to perform the examination.

We estimate that this expansion in the scope of practitioners who can receive Medicare payment for screening flexible sigmoidoscopies will increase beneficiary access to these screening services and will result in an increase in the number of covered exams that are performed. At the same time, we estimate that this final rule will result in a decrease in payments that are made for certain screening flexible sigmoidoscopies because they will be performed by nurse practitioners, physician assistants, and clinical nurse specialists, since services they provide are paid at 85 percent of the amount of payment that is made to physicians for the same screening service. Taking these factors into account, we estimate that this provision will result in negligible additional Medicare program costs. For a more detailed discussion of this provision see section II.B. of this preamble.

C. Services and Supplies Incident to a Physician's Professional Services—Conditions

Under this rule auxiliary personnel may provide services incident to the services of physicians (or other practitioners) who supervise them, regardless of the employment relationship. There are no costs or savings to the Medicare program associated with this provision. This provision could result in increased beneficiary access to the auxiliary personnel. For a more detailed discussion of this provision see section II.C. of this preamble.

D. Anesthesia Services—Anesthesia Base Units

As previously discussed in section II.D. of the preamble, with the exception of codes 00142 and 00147, we are using the same anesthesia base unit per anesthesia code as the ASA provides in its uniform relative value guide. There are eleven codes where our base unit value for an anesthesia code differed from the corresponding ASA base unit. Using the ASA base units resulted in an increase for 8 codes and a decrease for 3 codes. New and revised codes starting in CY 2000 and for subsequent years are evaluated on a code-specific basis under our usual process after we receive recommendations from the RUC. Thus, because of our review of the RUC recommendations, there could be differences between the ASA's guide and our base units beginning in CY 2000.

We have determined the budget neutrality impact on the anesthesia CF for the 11 codes for which CMS's base units are equal to the ASA's base units as well as the addition of 19 new anesthesia codes in CY 2002. The impact was determined by estimating the increase or decrease in base units between our base units and the ASA's base units for existing codes as well as the increase and decrease in base units between the new 2002 codes and the previous codes by which the services would have been reported. This results in an increase of approximately .2 percent in the 2002 anesthesia CF. For a more detailed discussion of this provision see section II.D. of this preamble.

E. Performance Measurement and Emerging Technology Codes

As previously discussed in section II.E. of the preamble, the AMA has developed two new categories of codes—performance codes and emerging technology. Allowing the performance measurement code to be recorded on Medicare billing forms will have no budgetary impact since we are not proposing payment for these codes. We are allowing for carrier pricing of the emerging technology codes.

We expect that the emerging technology codes will be used infrequently and may be used in place of ''unlisted'' procedure codes that are also carrier-priced. There would be few, if any, Medicare program costs associated with this proposal. For a more detailed discussion of this provision see section II.E. of this preamble.

F. BIPA Provisions Included in This Final Rule

The following provisions of the BIPA are discussed in detail in section III of this preamble. This final rule conforms the regulations text to the BIPA provisions. We showed the anticipated costs associated with the BIPA provisions in our August 2, 2001 proposed rule (66 FR 40400). We are showing that same table again in table 23 below.

TABLE 23.—MEDICARE COST ESTIMATES FOR BIPA 2000 PROVISIONS

[In millions]

BIPA provisions	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Sec. 101 Biennial Pelvic Examinations	10	20	20	20	20
Sec. 102 Screening Glaucoma	30	50	50	60	60
Sec. 103 Screening Colonoscopy	40	40	30	10	10
Sec. 104 Screening Mammography	30	40	40	40	50
Sec. 105 Medical Nutrition	20	50	60	70	70
Sec. 223 Telehealth Services	20	30	40	50	60
Sec. 432 Indian Health	60	70	80	80	90

1. Screening Mammography

As discussed in section III.A. of the preamble, the BIPA eliminates the statutorily prescribed payment rate for screening mammography and specifies that it will be paid under the physician fee schedule beginning January 1, 2002. To pay for the professional component of the screening mammography, we are using the work and malpractice RVUs that have been established for unilateral diagnostic mammography. We are establishing the practice expense RVUs for the professional component under the resource-based methodology. The process we used to establish the practice expense RVU for the TC is described in detail in section III.A. Currently, we pay for screening mammography under section 1834(c) of the Act. Payment for screening mammography under that section is not subject to the budget neutrality requirements that apply to physician fee schedule services under section 1848(c)(2)(B)(ii)(II) of the Act. However, effective January 1, 2002, screening mammography will be paid under the physician fee schedule and, thus, subject to the budget neutrality requirements that apply to physician fee schedule services. We will include the current payment amounts for screening mammography in aggregate physician fee schedule payments subject to the budget neutrality requirements. As a result, the BIPA requirement that we pay for screening mammography under the physician fee schedule will not result in an increase in Medicare program expenditures. However, the increase in payment for screening mammography under the physician fee schedule will be included in the budget neutrality adjustments that apply to physician fee schedule services. The BIPA also establishes a methodology for determining payment for certain types of new technology that are used in providing both diagnostic and screening mammography services. The statutory provisions are in effect from April 1, 2001 to December 31, 2001. The statute gives us the authority to determine whether separate codes and payment amounts are appropriate for screening and diagnostic mammography services that involve use of a new technology on or after January 1, 2002. We are establishing several new codes and fee schedule amounts for screening and diagnostic mammography services that involve use of a new technology. We believe this will help ensure that all Medicare beneficiaries have access to the benefits of mammography, including recent advances that further enhance the clinical capability of this vital health service for women. The BIPA provisions related to new technology mammography will result in the Medicare program costs shown in Table 23. The BIPA makes no changes to provisions for Medicare coverage of screening mammography.

2. Screening Pelvic Examinations

As discussed in section III.B. of the preamble, section 101 of the BIPA provides for expanded coverage for screening pelvic examinations (including a clinical breast examination) furnished on or after July 1, 2001. Specifically, the revised benefit will allow for biennial coverage of screening pelvic examination for all women who do not qualify under the law for annual coverage of such tests. We estimate that this change in the frequency of coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to a large number of physicians and other practitioners who provide these tests and for any medically necessary follow-up tests, or treatment that may be required as a result of the increased frequency of coverage of these tests. Medicare program expenditures associated with screening pelvic examinations have been included in the President's budget for Medicare expenditures. The impact of this provision is shown in Table 23.

3. Screening for Glaucoma

As discussed in section III.C. of the preamble, section 102 of the BIPA authorizes coverage of glaucoma screening examinations effective January 1, 2002, subject to certain frequency and other limitations. We believe services provided as part of glaucoma screening will often overlap with other services a physician provides during a patient encounter that is associated with a higher payment amount. We believe that physicians will more commonly provide glaucoma tests in conjunction with other services and will rarely provide only glaucoma screening to Medicare patients. Based on the projected utilization of these screening services and related medically necessary follow-up tests and treatment that may be required for the beneficiaries screened, we estimate that this new benefit will result in an increase in Medicare payments. These payments will be made to ophthalmologists or optometrists who will provide these screening tests and for any related follow-up tests and treatment that may be required. Medicare program expenditures associated with the BIPA provision that establishes coverage for screening glaucoma are shown in Table 23. The addition of the screening glaucoma benefit will allow a greater number of beneficiaries access to a preventive service.

4. Screening Colonoscopy

As discussed in section III.D. of the preamble, section 103 of the BIPA amended the Act to add coverage of screening colonoscopies once every 10 years for individuals not at high risk for colorectal cancer. We estimate that this new benefit will result in an increase in Medicare payments. These payments will be made to practitioners who will provide these screening tests and related follow-up tests and treatment that may be required. The addition of the screening colonoscopy benefit will allow beneficiaries who are not at high risk for colorectal cancer greater access to preventive services. The impact of this provision is shown in Table 23.

5. Medical Nutrition Therapy

As discussed in section III.E. of the preamble, section 105 of the BIPA

amended the Act to authorize Medicare coverage under Part B of medical nutrition therapy (MNT) for beneficiaries who have diabetes or renal disease, effective for services furnished on or after January 1, 2002. We are implementing this provision in 42 CFR at part 410, in subpart G. Specifically, the final rule discusses the education, experience, and licensing requirements for dietitians or nutritionists furnishing the service. In addition, the final rule discusses a referral requirement and the manner by which the medical nutrition therapy and diabetes outpatient self-management training benefits will be coordinated to avoid duplicate payment. We are also establishing payment amounts for these services under the physician fee schedule.

We estimate that this new benefit will result in an increase in Medicare payments. These payments will be made to dietitians and nutrition professionals who will provide these diagnostic therapy and counseling services. Costs to the Medicare program associated with this provision are shown in Table 23.

6. Telehealth

We estimate that the cost of providing office or other outpatient visits, consultation services, individual psychotherapy, and pharmacologic management in accordance with section 223 of the BIPA will be approximately $20 million in FY 2002 and approximately $60 million by FY 2006, as indicated above in Table 23.

This final rule does not mandate that entities provide consultation, office or other outpatient visits, individual psychotherapy or pharmacological management services via a telecommunications system. Thus, this final rule will not require entities to purchase telehealth equipment or to acquire the telecommunications infrastructure necessary to deliver these services via a telecommunications system. Therefore, this final rule does not impose costs associated with starting and operating a telehealth network.

7. Indian Health Services

As discussed in section III.G. of the preamble, section 432 of the BIPA authorizes payment under the physician fee schedule to physicians and certain practitioners for services furnished in a hospital and an ambulatory care clinic, whether provider-based or free-standing, of the Indian Health Service effective for services furnished on or after July 1, 2001. We are adding a new § 410.46 to conform our regulations to the statute. Costs to the Medicare program for this BIPA provision are shown in Table 23.

8. Pathology Services

As discussed in section III.H. of the preamble, in the November 2, 1999 physician fee schedule final rule (64 FR 59381), we stated that we would implement a policy to pay only hospitals for the TC of physician pathology services furnished to hospital inpatients. Before the effective date of this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology to a hospital inpatient. That regulation provided that for services furnished on or after January 1, 2001, the carriers would no longer pay claims to an independent laboratory under the physician fee schedule for the TC of physician pathology services furnished for hospital inpatients. Similar treatment was provided under the hospital outpatient prospective payment system for the TC of physician pathology services to hospital outpatients. We delayed implementation of this provision for one year; it was to take effect for services furnished on or after January 1, 2001. The delay was intended to allow independent laboratories and hospitals sufficient time to negotiate arrangements.

Section 542 of the BIPA requires Medicare to continue to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. This provision applies to TC services furnished during the 2-year period beginning on January 1, 2001.

In the November 2, 1999 final rule, we estimated that payment under the physician fee schedule for TC billings by independent laboratories would decrease by $6 million per year if the original proposal had been implemented on January 1, 2001. As a result of the BIPA, these savings are not realized for two years.

G. Update of the Codes for the Physician Self-Referral Prohibition

As discussed in section VI of this preamble, we are updating the list of codes used to define certain designated health services for the purposes of section 1877 of the Act. We are not making any substantive change to the description of any designated health service as set forth in the January 4, 2001 physician self-referral final rule (66 FR 856). Instead, we are merely updating our list of codes to conform to coding changes in the most recent publication of CPT and HCPCS codes. For this reason, we certify that the changes we are making will not have a significant economic effect on a substantial number of small entities or on the operations of a substantial number of small rural hospitals. For an in-depth discussion of the anticipated effects of the recent physician self-referral final rule, refer to the regulatory impact statement in that rule as published in the January 4, 2001 **Federal Register** (66 FR 856).

H. Budget-Neutrality

The increase in physician work RVUs will necessitate an adjustment to meet the statute's budget neutrality requirements. We are reducing the physician fee schedule CF by –0.46 percent (CF X 0.9954) to ensure that the increase in physician work RVUs remains budget neutral across all physician fee schedule services. Each year since the fee schedule has been implemented, our actuaries have determined any adjustments needed to meet the budget-neutrality requirement of the statute. A component of the actuarial determination of budget-neutrality involves estimating the impact of changes in the volume and intensity of physicians' services provided to Medicare beneficiaries as a result of the proposed changes to relative value units. Consistent with the provision in the November 1998 final rule, the actuaries would use a model that assumes a 30 percent volume-and-intensity response to price reductions. Based on the practice expense changes that will occur in 2002, the actuaries estimate that a –0.18 (CF X 0.9982) percent adjustment to the conversion factor is necessary to meet the budget neutrality requirements in the statute. If the assumed volume and intensity offset does not occur, the offset applied to the RVUs will be, in essence, returned because there will be a future year adjustment to the physician fee schedule update.

I. Impact on Beneficiaries

Although changes in physicians' payments when the physician fee schedule was implemented in 1992 were large, we detected no problems with beneficiary access to care. Furthermore, since beginning our transition to a resource-based practice expense system in 1999, we have not found that there are problems with beneficiary access to care.

J. Federalism

We have reviewed this proposed rule under the threshold criteria of EO 13132, Federalism, and we have determined that the proposed rule does

not significantly affect the rights, roles, and responsibilities of States.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare and Medicaid amends 42 CFR chapter IV as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 405.534, an introductory paragraph is added to read as follows:

§ 405.534 Limitation on payment for screening mammography services.

The provisions in paragraphs (a), (b), and (c) of this section apply for services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are paid under the physician fee schedule in accordance with § 414.2 of this chapter.

* * * * *

3. In § 405.535, the section heading is revised and the introductory text is amended by adding two sentences to the beginning to read as follows:

§ 405.535 Special rule for nonparticipating physicians and suppliers furnishing screening mammography services before January 1, 2002.

The provisions in this section apply for screening mammography services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are physician services pursuant to § 414.2 of this chapter paid under the physician fee schedule. * * *

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 410.3 is amended by revising paragraph (a)(1) to read as follows:

§ 410.3 Scope of benefits.

(a) * * *

(1) Medical and other health services such as physicians' services, outpatient services furnished by a hospital or a CAH, diagnostic tests, outpatient physical therapy and speech pathology services, rural health clinic services, Federally qualified health center services, IHS, Indian tribe, or tribal organization facility services, and outpatient renal dialysis services.

* * * * *

3. Section 410.10 is amended by adding paragraph (x) to read as follows:

§ 410.10 Medical and other health services: Included services.

* * * * *

(x) Services of physicians and other practitioners furnished in or at the direction of an IHS or Indian tribal hospital or clinic.

4. Section 410.22 is redesignated as § 410.21, § 410.23 is redesignated as § 410.22, and a new § 410.23 is added to read as follows:

§ 410.23 Screening for glaucoma: Conditions for and limitations on coverage.

(a) *Definitions*: As used in this section, the following definitions apply:

(1) *Direct supervision in the office setting* means the optometrist or the ophthalmologist must be present in the office suite and be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean the physician must be present in the room when the procedure is performed.

(2) *Eligible beneficiary* means individuals in the following high risk categories:

(i) Individual with diabetes mellitus;

(ii) Individual with a family history of glaucoma; or

(iii) African-Americans age 50 and over.

(3) *Screening for glaucoma* means the following procedures furnished to an individual for the early detection of glaucoma:

(i) A dilated eye examination with an intraocular pressure measurement.

(ii) A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.

(b) *Condition for coverage of screening for glaucoma.*

Medicare Part B pays for glaucoma screening examinations provided to eligible beneficiaries as described in paragraph (a)(2) of this section if they are furnished by or under the direct supervision in the office setting of an optometrist or ophthalmologist who is legally authorized to perform these services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or incident to a physician's professional service.

(c) *Limitations on coverage of glaucoma screening examinations.*

(1) Payment may not be made for a glaucoma screening examination that is performed for an individual who is not an eligible beneficiary as described in paragraph (a)(2) of this section.

(2) Payment may be made for a glaucoma screening examination that is performed on an individual who is an eligible beneficiary as described in paragraph (a)(2) of this section, after at least 11 months have passed following the month in which the last glaucoma screening examination was performed.

5. In § 410.26, paragraph (b) is redesignated as paragraph (c), paragraph (a) is redesignated as paragraph (b) and revised, a new paragraph (a) is added, and newly designated paragraph (c) is amended by adding a paragraph heading:

§ 410.26 Services and supplies incident to a physician's professional service: Conditions.

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Auxiliary personnel* means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner).

(2) *Direct supervision* means the level of supervision by the physician (or other practitioner) of auxiliary personnel as defined in § 410.32(b)(3)(ii).

(3) *Independent contractor* means an individual who performs part-time or full-time work for which the individual receives an IRS–1099 form.

(4) *Leased employment* means an employment relationship that is recognized by applicable State law and that is established by two employers by a contract such that one employer hires the services of an employee of the other employer.

(5) *Noninstitutional setting* means all settings other than a hospital or skilled nursing facility.

(6) *Practitioner* means a non-physician practitioner who is authorized by the Act to receive payment for services incident to his or her own services.

(7) *Services and supplies* means any services or supplies (including drugs or biologicals that are not usually self-administered) that are included in section 1861(s)(2)(A) of the Act and are not specifically listed in the Act as a separate benefit included in the Medicare program.

(b) Medicare Part B pays for services and supplies incident to the service of a physician (or other practitioner).

(1) Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.

(2) Services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.

(3) Services and supplies must be commonly furnished without charge or included in the bill of a physician (or other practitioner).

(4) Services and supplies must be of a type that are commonly furnished in the office or clinic of a physician (or other practitioner).

(5) Services and supplies must be furnished under the direct supervision of the physician (or other practitioner). The physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based.

(6) Services and supplies must be furnished by the physician, practitioner with an incident to benefit, or auxiliary personnel.

(7) A physician (or other practitioner) may be an employee or an independent contractor.

(c) *Limitation.* * * *

6. In § 410.37, paragraphs (d), (e)(2), and (g) are revised and paragraph (e)(3) is added to read as follows:

§ 410.37 Colorectal cancer screening tests: Conditions for and limitations on coverage.

* * * * *

(d) *Condition for coverage of flexible sigmoidoscopy screening.* Medicare Part B pays for a flexible sigmoidoscopy screening service if it is performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act), or by a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act and §§ 410.74, 410.75, and 410.76) who is authorized under State law to perform the examination.

(e) *Limitations on coverage of screening flexible sigmoidoscopies.*

* * *

(2) For an individual 50 years of age or over, except as described in paragraph (e)(3) of this section, payment may be made for screening flexible sigmoidoscopy after at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy or, as provided in paragraphs (h) and (i) of this section, the last screening barium enema was performed.

(3) In the case of an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section but who has had a screening colonoscopy performed, payment may be made for a screening flexible sigmoidosocopy only after at least 119 months have passed following the month in which the last screening colonoscopy was performed.

* * * * *

(g) *Limitations on coverage of screening colonoscopies.* (1) Effective for services furnished on or after January 1, 1998 through June 30, 2001, payment may not be made for a screening colonoscopy for an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section.

(2) Effective for services furnished on or after July 1, 2001, except as described in paragraph (g)(4) of this section, payment may be made for a screening colonoscopy performed for an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section, after at least 119 months have passed following the month in which the last screening colonoscopy was performed.

(3) Payment may be made for a screening colonoscopy performed for an individual who is at high risk for colorectal cancer as described in paragraph (a)(3) of this section, after at least 23 months have passed following the month in which the last screening colonoscopy was performed, or, as provided in paragraphs (h) and (i) of this section, the last screening barium enema was performed.

(4) In the case of an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section but who has had a screening flexible sigmoidoscopy performed, payment may be made for a screening colonoscopy only after at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy was performed.

* * * * *

7. Section 410.46 is added to read as follows:

§ 410.46 Physician and other practitioner services furnished in or at the direction of an IHS or Indian tribal hospital or clinic: Scope and conditions.

(a) Medicare Part B pays, in accordance with the physician fee schedule, for services furnished in or at the direction of a hospital or outpatient clinic (provider-based or free-standing) that is operated by the Indian Health Service (IHS) or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act). These services are subject to the same situations, terms, and conditions that would apply if the services were furnished in or at the direction of a hospital or clinic that is not operated by IHS or by an Indian tribe or tribal organization. Payments include health professional shortage areas incentive payments when the requirements for these incentive payments in § 414.42 of this chapter are met.

(b) Payment is not made under this section to the extent that Medicare otherwise pays for the same services under other provisions.

(c) Payment is made under these provisions for the following services:

(1) Services for which payment is made under the physician fee schedule in accordance with part 414 of this chapter.

(2) Services furnished by non-physician practitioners for which payment under Part B is made under the physician fee schedule.

(3) Services furnished by a physical therapist or occupational therapist, for which payment under Part B is made under the physician fee schedule.

(d) Payments under these provisions will be paid to the IHS or tribal hospital or clinic.

8. In § 410.56, paragraphs (b)(1), the introductory text of (b)(2), and (b)(3) are revised to read as follows:

§ 410.56 Screening pelvic examinations.

* * * * *

(b) * * *

(1) *General rule.* Except as specified in paragraphs (b)(2) and (b)(3) of this section, payment may be made for a pelvic examination performed on an asymptomatic woman only if the individual has not had a pelvic examination paid for by Medicare during the preceding 23 months following the month in which her last Medicare-covered screening pelvic examination was performed.

(2) *More frequent screening based on high-risk factors.* Subject to the limitation as specified in paragraph (b)(4) of this section, payment may be made for a screening pelvic examination performed more frequently than once every 24 months if the test is performed by a physician or other practitioner specified in paragraph (a) of this section, and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer or vaginal cancer, as determined in accordance with the following risk factors:

* * * * *

(3) *More frequent screening for women of childbearing age.* Subject to the limitation as specified in paragraph (b)(4) of this section, payment may be made for a screening pelvic examination performed more frequently than once every 24 months if the test is performed by a physician or other practitioner as specified in paragraph (a) of this section for a woman of childbearing age who has had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding 3 years. The term ''woman of childbearing age'' means a woman who is premenopausal, and has been determined by a physician, or a qualified practitioner, as specified in paragraph (a) of this section, to be of childbearing age, based on her medical history or other findings.

* * * * *

9. Section 410.78 is revised to read as follows:

§ 410.78 Office and other outpatient visits, consultation, individual psychotherapy and pharmacologic management via an interactive telecommunications system.

(a) *Definitions.* For the purposes of this section the following definitions apply:

(1) *Asynchronous store and forward technologies* means the transmission of a patient's medical information from an originating site to the physician or practitioner at the distant site. The physician or practitioner at the distant site can review the medical case without the patient being present. An asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs visualized by a telecommunications system must be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis and or treatment plan. Dermatological photographs, for example, a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this provision.

(2) *Distant site* means the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system.

(3) *Interactive telecommunications system* means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

(4) *Originating site* means, for purposes of a consultation, office or other outpatient visit, individual psychotherapy, or pharmacologic management via an interactive telecommunications system, the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous store and forward telecommunications technologies, the only originating sites are Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, individual psychotherapy, and pharmacologic management furnished by means of an interactive telecommunications system if the following conditions are met:

(1) The physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (that is, professional consultations, office and other outpatient visits, individual psychotherapy, and pharmacologic management), he or she may bill for, and receive payment for, this service when delivered via a telecommunications system.

(2) The practitioner at the distant site is one of the following:

(i) A physician as described in § 410.20.

(ii) A physician assistant as described § 410.74.

(iii) A nurse practitioner as described in § 410.75.

(iv) A clinical nurse specialist as described in § 410.76.

(v) A nurse-midwife as described in § 410.77.

(vi) A clinical psychologist as described in § 410.71.

(vii) A clinical social worker as described in § 410.73.

(3) The services are furnished to a beneficiary at an originating site, which is one of the following:

(i) The office of a physician or practitioner.

(ii) A critical access hospital (as described in section 1861(mm)(1) of the Act).

(iii) A rural health clinic (as described in section 1861(aa)(2) of the Act).

(iv) A Federally qualified health center (as defined in section 1861(aa)(4) of the Act).

(v) A hospital (as defined in section 1861(e) of the Act).

(4) Originating sites must be located in either a rural health professional shortage area as defined under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a Metropolitan Statistical Area as defined in section 1886(d)(2)(D) of the Act. Entities participating in a Federal telemedicine demonstration project that have been approved by, or receive funding from, the Secretary as of December 31, 2000 qualify as an eligible originating site regardless of geographic location.

(5) The medical examination of the patient is under the control of the physician or practitioner at the distant site.

(c) *Telepresenter not required.* A telepresenter is not required as a condition of payment unless a telepresenter is medically necessary as determined by the physician or practitioner at the distant site.

(d) *Exception to the interactive telecommunications system requirement.* For Federal telemedicine demonstration programs conducted in Alaska or Hawaii only, Medicare payment is permitted for telehealth when asynchronous store and forward technologies, in single or multimedia formats, are used as a substitute for an interactive telecommunications system.

(e) *Limitation.* A clinical psychologist and a clinical social worker may bill and receive payment for individual psychotherapy via a telecommunications system, but may

not seek payment for medical evaluation and management services.

10. A new subpart G is added to read as follows:

Subpart G—Medical Nutrition Therapy

Sec.
410.130 Definitions.
410.132 Medical nutrition therapy.
410.134 Provider qualifications.

Subpart G—Medical Nutrition Therapy

§ 410.130 Definitions.

For the purposes of this subpart, the following definitions apply:

Chronic renal insufficiency means the stage of renal disease associated with a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate [GFR] 13–50 ml/min/1.73m^2).

Diabetes means diabetes mellitus consisting of two types. Type 1 is an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency. Type 2 is familial hyperglycemia that occurs primarily in adults but can also occur in children and adolescents. It is caused by an insulin resistance whose etiology is multiple and not totally understood. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy. The diagnostic criterion for a diagnosis of diabetes for a fasting glucose tolerance test is greater than or equal to 126 mg/dL.

Episode of care means services covered in a 12-month time period when coordinated with initial diabetes self-management training (DSMT) and one calendar year for each year thereafter, starting with the assessment and including all covered interventions based on referral(s) from a physician as specified in § 410.132(c). The time period covered for gestational diabetes extends only until the pregnancy ends.

Medical nutrition therapy services means nutritional diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing diabetes or a renal disease.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section of 1101(a)(7) of the Act).

Renal disease means chronic renal insufficiency, end-stage renal disease when dialysis is not received, or the medical condition of a beneficiary for 36 months after kidney transplant.

Treating physician means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease.

§ 410.132 Medical nutrition therapy.

(a) *Conditions for coverage of MNT services.* Medicare Part B pays for MNT services provided by a registered dietitian or nutrition professional as defined in § 410.134 when the beneficiary is referred for the service by the treating physician. Services covered consist of face-to-face nutritional assessments and interventions in accordance with nationally accepted dietary or nutritional protocols.

(b) *Limitations on coverage of MNT services.*

(1) MNT services based on a diagnosis of renal disease as described in this subpart are not covered for beneficiaries receiving maintenance dialysis for which payment is made under section 1881 of the Act.

(2) A beneficiary may only receive the maximum number of hours covered under the DSMT benefit for both DSMT and MNT during the initial DSMT training period unless additional hours are determined to be medically necessary under the national coverage determination process.

(3) In years when the beneficiary is eligible for MNT and follow-up DSMT, the beneficiary may only receive the maximum number of hours covered under MNT unless additional hours are determined to be medically necessary under the national coverage determination process.

(4) If a beneficiary has both diabetes and renal disease, the beneficiary may only receive the maximum number of hours covered under the renal MNT benefit in one episode of care unless he or she is receiving initial DSMT services, in which case the beneficiary would receive whichever is greater.

(5) An exception to the maximum number of hours in (b)(2), (3), and (4) of this section may be made when the treating physician determines that there is a change of diagnosis, medical condition, or treatment regimen related to diabetes or renal disease that requires a change in MNT during an episode of care.

(c) *Referrals.* Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease as defined in this subpart with documentation maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and any additional assessments or interventions required by a change of diagnosis, medical condition, or treatment regimen during an episode of care.

§ 410.134 Provider qualifications.

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. ''Registered dietitian or nutrition professional'' means an individual who, on or after December 22, 2000:

(a) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.

(b) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

(c) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a ''registered dietitian'' by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a) and (b) of this section.

(d) *Exceptions.*

(i) A dietitian or nutritionist licensed or certified in a State as of December 21, 2000 is not required to meet the requirements of (a) and (b) of this section.

(ii) A ''registered dietician'' in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements of (a) and (b) of this section.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 411.15, paragraph (a)(1) is revised, and a new paragraph (k)(10) is added to read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic examinations, prostate cancer screening

tests, or glaucoma screening exams that meet the criteria specified in paragraphs (k)(6) through (k)(10) of this section.

* * * * *

(k) * * *

(10) In the case of screening exams for glaucoma, for the purpose of early detection of glaucoma, subject to the conditions and limitations specified in § 410.23 of this chapter.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

2. In 414.2, the definition of ''Physician services'' is amended by adding a new paragraph (8) to read as follows:

§ 414.2 Definitions.

* * * * *

Physician Services * * *

(8) Screening mammography services.

* * * * *

3. A new § 414.64 is added to read as follows:

§ 414.64 Payment for medical nutrition therapy.

(a) *Payment under the physician fee schedule.* Medicare payment for medical nutrition therapy is made under the physician fee schedule in accordance with subpart B of this part. Payment to non-physician professionals, as specified in paragraph (b) of this section, is the lesser of the actual charges or 80 percent of 85 percent of the physician fee schedule amount.

(b) *To whom payment may be made.* Payment may be made to a registered dietician or nutrition professional qualified to furnish medical nutrition therapy in accordance with part 410, subpart G of this chapter.

(c) *Effective date of payment.* Medicare pays suppliers of medical nutrition therapy on or after the effective date of enrollment of the supplier at the carrier.

(d) *Limitation on payment.* Payment is made only for documented nutritional therapy sessions actually attended by the beneficiary.

(e) *Other conditions for fee-for-service payment.* Payment is made only if the beneficiary:

(1) Is not an inpatient of a hospital, SNF, nursing home, or hospice.

(2) Is not receiving services in an RHC, FQHC or ESRD dialysis facility.

4. Section 414.65 is revised to read as follows:

§ 414.65 Payment for office or other outpatient visits, consultation, individual psychotherapy, and pharmacologic management via interactive telecommunications systems.

(a) *Professional service.* Medicare payment for the professional service via an interactive telecommunications system is made according to the following limitations:

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, and pharmacologic management via an interactive telecommunications system is equal to the current fee schedule amount applicable to services of the physician or practitioner.

(2) Only the physician or practitioner at the distant site may bill and receive payment for the professional service via an interactive telecommunications system.

(3) Payments made to the physician or practitioner at the distant site, including deductible and coinsurance, for the professional service may not be shared with the referring practitioner or telepresenter.

(b) *Originating site facility fee.* For office or other outpatient visits, consultation, individual psychotherapy, or pharmacologic management services delivered via an interactive telecommunications system furnished on or after October 1, 2001:

(1) For services furnished on or after October 1, 2001 through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of $20. For services furnished on or after January 1 of each subsequent year, the facility fee for the originating site will be updated by the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act.

(2) Only the originating site may bill for the originating site facility fee and only on an assignment-related basis. The distant site physician or practitioner may not bill for or receive payment for facility fees associated with the professional service furnished via an interactive telecommunications system.

(c) *Deductible and coinsurance apply.* The payment for the professional service and originating site facility fee is subject to the coinsurance and deductible requirements of sections 1833(a)(1) and (b) of the Act.

(d) *Assignment required for physicians, practitioners, and originating sites.* Payment to physicians, practitioners, and originating sites is made only on an assignment-related basis.

(e) *Sanctions.* A distant site practitioner or originating site facility may be subject to the applicable sanctions provided for in chapter IV, part 402 and chapter V, parts 1001, 1002, and 1003 of this title if he or she does any of the following:

(1) Knowingly and willfully bills or collects for services in violation of the limitation of this section.

(2) Fails to timely correct excess charges by reducing the actual charge billed for the service in an amount that does not exceed the limiting charge for the service or fails to timely refund excess collections.

(3) Fails to submit a claim on a standard form for services provided for which payment is made on a fee schedule basis.

(4) Imposes a charge for completing and submitting the standard claims form.

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

1. The authority citation for part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 415.130 is amended by:

A. Redesignating paragraphs (a), (b), and (c) as paragraphs (b), (c), and (d).

B. Adding a new paragraph (a).

C. Amending newly designated paragraph (b)(3) by removing the reference ''paragraph (b)'' and adding ''paragraph (c)'' in its place.

D. Amending newly designated paragraph (b)(4) by removing the reference ''paragraphs (b)(1), (b)(3), and (b)(4)'' and adding ''paragraphs (c)(1), (c)(3), and (c)(4)'' in their place.

E. Revising newly designated paragraph (d).

§ 415.130 Conditions for payment: Physician pathology services.

(a) *Definitions.* The following definitions are used in this section.

(1) *Covered hospital* means, with respect to an inpatient or an outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for this technical component directly to a Medicare carrier.

(2) *Fee-for-service Medicare beneficiaries* means those beneficiaries who are entitled to benefits under Part

A or are enrolled under Part B of Title XVIII of the Act or both and are not enrolled in any of the following:

(i) A Medicare+Choice plan under Part C of Title XVIII of the Act.

(ii) A plan offered by an eligible organization under section 1876 of the Act;

(iii) A program of all-inclusive care for the elderly (PACE) under 1894 of the Act; or

(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987.

* * * * *

(d) *Physician pathology services furnished by an independent laboratory.* The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient before January 1, 2001 may be paid to the laboratory on a fee schedule basis. After December 31, 2000 but before January 1, 2003, if an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service Medicare beneficiary who is an inpatient or outpatient of a covered hospital, the carrier will treat the technical component as a service for which payment will be made to the laboratory under the physician fee schedule. For these two years the service will not be treated as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of the Act or as an outpatient hospital service for which payment is made to the hospital under section 1833(t) of the Act. After December 31, 2002, the technical component for physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient is paid only to the hospital.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 22, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 24, 2001.

Tommy G. Thompson,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2002. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

Addendum B—2002 Relative Value Units and Related Information Used in Determining Medicare Payments for 2002

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier −26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: One for the global values (both professional and technical); one for modifier −26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier −53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

D = Deleted code. These codes are deleted effective with the beginning of the calendar year.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.

H = Deleted modifier (code used to have modifier of TC and PC).

I = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for the reporting of, and payment for, these services. This indicator is treated in the same manner as status indicator ''G''. It's use allows for more efficient processing of Medicare claims.

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these

services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of ''physicians' services'' for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2000. Codes that are not used for Medicare payment are identified with a ''+.''

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2000.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = The code is part of another service and falls within the global period for the other service.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
0001T	.....	C	Endovas repr abdo ao aneurys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0002T	.....	C	Endovas repr abdo ao aneurys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0003T	.....	C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0005T	.....	C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0006T	.....	C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0007T	.....	C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T	.....	C	Upper gi endoscopy w/suture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0009T	.....	C	Endometrial cryoablation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0010T	.....	C	Tb test, gamma interferon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0012T	.....	C	Osteochondral knee autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0013T	.....	C	Osteochondral knee allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0014T	.....	C	Meniscal transplant, knee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0016T	.....	C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T	.....	C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0018T	.....	C	Transcranial magnetic stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T	.....	C	Extracorp shock wave tx, ms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0020T	.....	C	Extracorp shock wave tx, ft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0021T	.....	C	Fetal oximetry, trnsvag/cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0023T	.....	C	Phenotype drug test, hiv 1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T	.....	C	Transcath cardiac reduction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0025T	.....	C	Ultrasonic pachymetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T	.....	C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021	.....	A	Fna w/o image	1.27	1.02	NA	0.10	2.39	NA	XXX
10021	26	A	Fna w/o image	1.27	0.55	0.55	0.07	1.89	1.89	XXX
10021	TC	A	Fna w/o image	0.00	0.47	NA	0.03	0.50	NA	XXX
10022	.....	A	Fna w/image	1.27	1.11	NA	0.08	2.46	NA	XXX
10022	26	A	Fna w/image	1.27	0.48	0.48	0.05	1.80	1.80	XXX
10022	TC	A	Fna w/image	0.00	0.63	NA	0.03	0.66	NA	XXX
10040	.....	A	Acne surgery	1.18	1.00	0.54	0.05	2.23	1.77	010
10060	.....	A	Drainage of skin abscess	1.17	1.51	0.70	0.08	2.76	1.95	010
10061	.....	A	Drainage of skin abscess	2.40	1.88	1.48	0.17	4.45	4.05	010
10080	.....	A	Drainage of pilonidal cyst	1.17	2.18	0.75	0.09	3.44	2.01	010
10081	.....	A	Drainage of pilonidal cyst	2.45	3.02	1.61	0.19	5.66	4.25	010
10120	.....	A	Remove foreign body	1.22	1.52	0.36	0.10	2.84	1.68	010
10121	.....	A	Remove foreign body	2.69	2.99	1.83	0.25	5.93	4.77	010
10140	.....	A	Drainage of hematoma/fluid	1.53	1.54	0.90	0.15	3.22	2.58	010
10160	.....	A	Puncture drainage of lesion	1.20	0.74	0.43	0.11	2.05	1.74	010
10180	.....	A	Complex drainage, wound	2.25	1.51	1.33	0.25	4.01	3.83	010
11000	.....	A	Debride infected skin	0.60	0.66	0.24	0.05	1.31	0.89	000
11001	.....	A	Debride infected skin add-on	0.30	0.37	0.11	0.02	0.69	0.43	ZZZ
11010	.....	A	Debride skin, fx	4.20	2.53	2.10	0.45	7.18	6.75	010
11011	.....	A	Debride skin/muscle, fx	4.95	3.90	2.69	0.53	9.38	8.17	000
11012	.....	A	Debride skin/muscle/bone, fx	6.88	5.52	4.35	0.89	13.29	12.12	000
11040	.....	A	Debride skin, partial	0.50	0.55	0.22	0.05	1.10	0.77	000
11041	.....	A	Debride skin, full	0.82	0.69	0.34	0.08	1.59	1.24	000
11042	.....	A	Debride skin/tissue	1.12	1.04	0.47	0.11	2.27	1.70	000

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
11043	.....	A	Debride tissue/muscle	2.38	2.72	1.42	0.24	5.34	4.04	010
11044	.....	A	Debride tissue/muscle/bone	3.06	3.30	1.86	0.34	6.70	5.26	010
11055	.....	R	Trim skin lesion	0.43	0.52	0.19	0.02	0.97	0.64	000
11056	.....	R	Trim skin lesions, 2 to 4	0.61	0.59	0.26	0.03	1.23	0.90	000
11057	.....	R	Trim skin lesions, over 4	0.79	0.66	0.34	0.04	1.49	1.17	000
11100	.....	A	Biopsy of skin lesion	0.81	1.49	0.38	0.04	2.34	1.23	000
11101	.....	A	Biopsy, skin add-on	0.41	0.71	0.20	0.02	1.14	0.63	ZZZ
11200	.....	A	Removal of skin tags	0.77	1.20	0.32	0.04	2.01	1.13	010
11201	.....	A	Remove skin tags add-on	0.29	0.53	0.12	0.02	0.84	0.43	ZZZ
11300	.....	A	Shave skin lesion	0.51	1.05	0.22	0.03	1.59	0.76	000
11301	.....	A	Shave skin lesion	0.85	1.12	0.39	0.04	2.01	1.28	000
11302	.....	A	Shave skin lesion	1.05	1.21	0.49	0.05	2.31	1.59	000
11303	.....	A	Shave skin lesion	1.24	1.36	0.55	0.06	2.66	1.85	000
11305	.....	A	Shave skin lesion	0.67	0.77	0.29	0.04	1.48	1.00	000
11306	.....	A	Shave skin lesion	0.99	1.02	0.44	0.05	2.06	1.48	000
11307	.....	A	Shave skin lesion	1.14	1.15	0.51	0.05	2.34	1.70	000
11308	.....	A	Shave skin lesion	1.41	1.29	0.62	0.07	2.77	2.10	000
11310	.....	A	Shave skin lesion	0.73	1.15	0.34	0.04	1.92	1.11	000
11311	.....	A	Shave skin lesion	1.05	1.24	0.51	0.05	2.34	1.61	000
11312	.....	A	Shave skin lesion	1.20	1.32	0.58	0.06	2.58	1.84	000
11313	.....	A	Shave skin lesion	1.62	1.63	0.74	0.09	3.34	2.45	000
11400	.....	A	Removal of skin lesion	0.91	1.68	0.36	0.06	2.65	1.33	010
11401	.....	A	Removal of skin lesion	1.32	1.83	0.53	0.09	3.24	1.94	010
11402	.....	A	Removal of skin lesion	1.61	2.61	0.98	0.12	4.34	2.71	010
11403	.....	A	Removal of skin lesion	1.92	2.84	1.12	0.16	4.92	3.20	010
11404	.....	A	Removal of skin lesion	2.20	3.02	1.19	0.18	5.40	3.57	010
11406	.....	A	Removal of skin lesion	2.76	3.33	1.41	0.25	6.34	4.42	010
11420	.....	A	Removal of skin lesion	1.06	1.52	0.44	0.08	2.66	1.58	010
11421	.....	A	Removal of skin lesion	1.53	1.84	0.64	0.11	3.48	2.28	010
11422	.....	A	Removal of skin lesion	1.76	2.60	1.08	0.14	4.50	2.98	010
11423	.....	A	Removal of skin lesion	2.17	3.02	1.26	0.17	5.36	3.60	010
11424	.....	A	Removal of skin lesion	2.62	3.20	1.43	0.21	6.03	4.26	010
11426	.....	A	Removal of skin lesion	3.78	3.81	1.89	0.34	7.93	6.01	010
11440	.....	A	Removal of skin lesion	1.15	2.26	0.53	0.08	3.49	1.76	010
11441	.....	A	Removal of skin lesion	1.61	2.48	0.74	0.11	4.20	2.46	010
11442	.....	A	Removal of skin lesion	1.87	2.91	1.30	0.14	4.92	3.31	010
11443	.....	A	Removal of skin lesion	2.49	3.41	1.64	0.18	6.08	4.31	010
11444	.....	A	Removal of skin lesion	3.42	3.92	2.08	0.25	7.59	5.75	010
11446	.....	A	Removal of skin lesion	4.49	4.37	2.58	0.30	9.16	7.37	010
11450	.....	A	Removal, sweat gland lesion	2.73	4.20	1.03	0.26	7.19	4.02	090
11451	.....	A	Removal, sweat gland lesion	3.95	5.23	1.33	0.39	9.57	5.67	090
11462	.....	A	Removal, sweat gland lesion	2.51	4.32	0.98	0.23	7.06	3.72	090
11463	.....	A	Removal, sweat gland lesion	3.95	5.67	1.67	0.40	10.02	6.02	090
11470	.....	A	Removal, sweat gland lesion	3.25	4.97	1.26	0.30	8.52	4.81	090
11471	.....	A	Removal, sweat gland lesion	4.41	5.54	1.74	0.40	10.35	6.55	090
11600	.....	A	Removal of skin lesion	1.41	2.48	1.08	0.09	3.98	2.58	010
11601	.....	A	Removal of skin lesion	1.93	2.52	1.36	0.12	4.57	3.41	010
11602	.....	A	Removal of skin lesion	2.09	2.66	1.40	0.13	4.88	3.62	010
11603	.....	A	Removal of skin lesion	2.35	2.93	1.49	0.16	5.44	4.00	010
11604	.....	A	Removal of skin lesion	2.58	3.27	1.56	0.18	6.03	4.32	010
11606	.....	A	Removal of skin lesion	3.43	3.88	1.85	0.28	7.59	5.56	010
11620	.....	A	Removal of skin lesion	1.34	2.47	1.09	0.09	3.90	2.52	010
11621	.....	A	Removal of skin lesion	1.97	2.56	1.41	0.12	4.65	3.50	010
11622	.....	A	Removal of skin lesion	2.34	2.87	1.60	0.15	5.36	4.09	010
11623	.....	A	Removal of skin lesion	2.93	3.30	1.86	0.20	6.43	4.99	010
11624	.....	A	Removal of skin lesion	3.43	3.72	2.08	0.25	7.40	5.76	010
11626	.....	A	Removal of skin lesion	4.30	4.48	2.57	0.35	9.13	7.22	010
11640	.....	A	Removal of skin lesion	1.53	2.51	1.29	0.10	4.14	2.92	010
11641	.....	A	Removal of skin lesion	2.44	2.94	1.78	0.15	5.53	4.37	010
11642	.....	A	Removal of skin lesion	2.93	3.37	2.03	0.18	6.48	5.14	010
11643	.....	A	Removal of skin lesion	3.50	3.83	2.32	0.24	7.57	6.06	010
11644	.....	A	Removal of skin lesion	4.55	4.81	2.95	0.33	9.69	7.83	010
11646	.....	A	Removal of skin lesion	5.95	5.68	3.77	0.46	12.09	10.18	010
11719	.....	R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
11720	.....	A	Debride nail, 1–5	0.32	0.34	0.13	0.02	0.68	0.47	000
11721	.....	A	Debride nail, 6 or more	0.54	0.44	0.22	0.04	1.02	0.80	000
11730	.....	A	Removal of nail plate	1.13	0.83	0.46	0.09	2.05	1.68	000
11732	.....	A	Remove nail plate, add-on	0.57	0.30	0.24	0.05	0.92	0.86	ZZZ
11740	.....	A	Drain blood from under nail	0.37	0.81	0.14	0.03	1.21	0.54	000
11750	.....	A	Removal of nail bed	1.86	1.75	0.78	0.16	3.77	2.80	010
11752	.....	A	Remove nail bed/finger tip	2.67	2.20	1.77	0.33	5.20	4.77	010
11755	.....	A	Biopsy, nail unit	1.31	1.10	0.60	0.06	2.47	1.97	000
11760	.....	A	Repair of nail bed	1.58	1.80	1.28	0.17	3.55	3.03	010

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
11762		A	Reconstruction of nail bed	2.89	2.28	1.95	0.32	5.49	5.16	010
11765		A	Excision of nail fold, toe	0.69	1.14	0.51	0.05	1.88	1.25	010
11770		A	Removal of pilonidal lesion	2.61	3.11	1.26	0.24	5.96	4.11	010
11771		A	Removal of pilonidal lesion	5.74	5.80	4.01	0.56	12.10	10.31	090
11772		A	Removal of pilonidal lesion	6.98	6.95	4.44	0.68	14.61	12.10	090
11900		A	Injection into skin lesions	0.52	0.77	0.23	0.02	1.31	0.77	000
11901		A	Added skin lesions injection	0.80	0.89	0.38	0.03	1.72	1.21	000
11920		R	Correct skin color defects	1.61	2.25	0.81	0.17	4.03	2.59	000
11921		R	Correct skin color defects	1.93	2.78	1.02	0.21	4.92	3.16	000
11922		R	Correct skin color defects	0.49	0.40	0.26	0.05	0.94	0.80	ZZZ
11950		R	Therapy for contour defects	0.84	1.23	0.47	0.06	2.13	1.37	000
11951		R	Therapy for contour defects	1.19	1.47	0.49	0.10	2.76	1.78	000
11952		R	Therapy for contour defects	1.69	1.65	0.64	0.17	3.51	2.50	000
11954		R	Therapy for contour defects	1.85	2.62	0.97	0.19	4.66	3.01	000
11960		A	Insert tissue expander(s)	9.08	NA	11.54	0.88	NA	21.50	090
11970		A	Replace tissue expander	7.06	NA	5.15	0.77	NA	12.98	090
11971		A	Remove tissue expander(s)	2.13	6.10	4.07	0.21	8.44	6.41	090
11975		N	Insert contraceptive cap	+1.48	1.58	0.59	0.14	3.20	2.21	XXX
11976		R	Removal of contraceptive cap	1.78	1.72	0.69	0.17	3.67	2.64	000
11977		N	Removal/reinsert contra cap	+3.30	2.31	1.32	0.31	5.92	4.93	XXX
11980		A	Implant hormone pellet(s)	1.48	1.14	0.58	0.10	2.72	2.16	000
11981		A	Insert drug implant device	1.48	1.58	0.59	0.14	3.20	2.21	XXX
11982		A	Remove drug implant device	1.78	1.70	0.71	0.17	3.65	2.66	XXX
11983		A	Remove/insert drug implant	3.30	2.31	1.32	0.31	5.92	4.93	XXX
12001		A	Repair superficial wound(s)	1.70	2.13	0.44	0.13	3.96	2.27	010
12002		A	Repair superficial wound(s)	1.86	2.21	0.95	0.15	4.22	2.96	010
12004		A	Repair superficial wound(s)	2.24	2.47	1.07	0.17	4.88	3.48	010
12005		A	Repair superficial wound(s)	2.86	3.04	1.25	0.23	6.13	4.34	010
12006		A	Repair superficial wound(s)	3.67	3.59	1.59	0.31	7.57	5.57	010
12007		A	Repair superficial wound(s)	4.12	4.26	1.85	0.37	8.75	6.34	010
12011		A	Repair superficial wound(s)	1.76	2.30	0.45	0.14	4.20	2.35	010
12013		A	Repair superficial wound(s)	1.99	2.45	0.99	0.16	4.60	3.14	010
12014		A	Repair superficial wound(s)	2.46	2.72	1.11	0.18	5.36	3.75	010
12015		A	Repair superficial wound(s)	3.19	3.38	1.31	0.24	6.81	4.74	010
12016		A	Repair superficial wound(s)	3.93	3.89	1.58	0.32	8.14	5.83	010
12017		A	Repair superficial wound(s)	4.71	NA	1.93	0.39	NA	7.03	010
12018		A	Repair superficial wound(s)	5.53	NA	2.18	0.46	NA	8.17	010
12020		A	Closure of split wound	2.62	2.51	1.44	0.24	5.37	4.30	010
12021		A	Closure of split wound	1.84	1.65	1.02	0.19	3.68	3.05	010
12031		A	Layer closure of wound(s)	2.15	2.21	0.81	0.15	4.51	3.11	010
12032		A	Layer closure of wound(s)	2.47	2.84	1.36	0.15	5.46	3.98	010
12034		A	Layer closure of wound(s)	2.92	3.12	1.51	0.21	6.25	4.64	010
12035		A	Layer closure of wound(s)	3.43	3.20	1.73	0.30	6.93	5.46	010
12036		A	Layer closure of wound(s)	4.05	5.33	2.50	0.41	9.79	6.96	010
12037		A	Layer closure of wound(s)	4.67	5.57	2.86	0.49	10.73	8.02	010
12041		A	Layer closure of wound(s)	2.37	2.41	0.87	0.17	4.95	3.41	010
12042		A	Layer closure of wound(s)	2.74	3.03	1.49	0.17	5.94	4.40	010
12044		A	Layer closure of wound(s)	3.14	3.22	1.67	0.24	6.60	5.05	010
12045		A	Layer closure of wound(s)	3.64	3.54	1.93	0.34	7.52	5.91	010
12046		A	Layer closure of wound(s)	4.25	6.24	2.62	0.40	10.89	7.27	010
12047		A	Layer closure of wound(s)	4.65	7.21	2.86	0.41	12.27	7.92	010
12051		A	Layer closure of wound(s)	2.47	3.11	1.49	0.16	5.74	4.12	010
12052		A	Layer closure of wound(s)	2.77	3.00	1.47	0.17	5.94	4.41	010
12053		A	Layer closure of wound(s)	3.12	3.20	1.63	0.20	6.52	4.95	010
12054		A	Layer closure of wound(s)	3.46	3.52	1.72	0.25	7.23	5.43	010
12055		A	Layer closure of wound(s)	4.43	4.49	2.27	0.35	9.27	7.05	010
12056		A	Layer closure of wound(s)	5.24	7.31	3.26	0.43	12.98	8.93	010
12057		A	Layer closure of wound(s)	5.96	6.31	3.66	0.50	12.77	10.12	010
13100		A	Repair of wound or lesion	3.12	3.39	1.93	0.21	6.72	5.26	010
13101		A	Repair of wound or lesion	3.92	3.59	2.39	0.22	7.73	6.53	010
13102		A	Repair wound/lesion add-on	1.24	0.75	0.60	0.10	2.09	1.94	ZZZ
13120		A	Repair of wound or lesion	3.30	3.48	1.95	0.23	7.01	5.48	010
13121		A	Repair of wound or lesion	4.33	3.84	2.52	0.25	8.42	7.10	010
13122		A	Repair wound/lesion add-on	1.44	0.89	0.67	0.12	2.45	2.23	ZZZ
13131		A	Repair of wound or lesion	3.79	3.75	2.30	0.25	7.79	6.34	010
13132		A	Repair of wound or lesion	5.95	4.57	3.38	0.32	10.84	9.65	010
13133		A	Repair wound/lesion add-on	2.19	1.23	1.08	0.17	3.59	3.44	ZZZ
13150		A	Repair of wound or lesion	3.81	5.19	2.75	0.29	9.29	6.85	010
13151		A	Repair of wound or lesion	4.45	5.07	3.19	0.28	9.80	7.92	010
13152		A	Repair of wound or lesion	6.33	5.78	4.14	0.38	12.49	10.85	010
13153		A	Repair wound/lesion add-on	2.38	1.38	1.20	0.18	3.94	3.76	ZZZ
13160		A	Late closure of wound	10.48	NA	6.47	1.19	NA	18.14	090
14000		A	Skin tissue rearrangement	5.89	7.58	4.83	0.46	13.93	11.18	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
14001	.....	A	Skin tissue rearrangement	8.47	8.72	6.18	0.65	17.84	15.30	090
14020	.....	A	Skin tissue rearrangement	6.59	8.05	5.56	0.50	15.14	12.65	090
14021	.....	A	Skin tissue rearrangement	10.06	9.29	7.38	0.69	20.04	18.13	090
14040	.....	A	Skin tissue rearrangement	7.87	8.19	6.27	0.53	16.59	14.67	090
14041	.....	A	Skin tissue rearrangement	11.49	9.90	8.17	0.68	22.07	20.34	090
14060	.....	A	Skin tissue rearrangement	8.50	8.64	7.13	0.59	17.73	16.22	090
14061	.....	A	Skin tissue rearrangement	12.29	10.85	9.08	0.75	23.89	22.12	090
14300	.....	A	Skin tissue rearrangement	11.76	10.11	8.68	0.88	22.75	21.32	090
14350	.....	A	Skin tissue rearrangement	9.61	NA	6.48	1.09	NA	17.18	090
15000	.....	A	Skin graft	4.00	2.51	1.91	0.37	6.88	6.28	000
15001	.....	A	Skin graft add-on	1.00	0.64	0.43	0.11	1.75	1.54	ZZZ
15050	.....	A	Skin pinch graft	4.30	4.98	4.12	0.46	9.74	8.88	090
15100	.....	A	Skin split graft	9.05	6.27	6.26	0.94	16.26	16.25	090
15101	.....	A	Skin split graft add-on	1.72	1.40	0.76	0.18	3.30	2.66	ZZZ
15120	.....	A	Skin split graft	9.83	8.62	6.97	0.87	19.32	17.67	090
15121	.....	A	Skin split graft add-on	2.67	1.83	1.23	0.27	4.77	4.17	ZZZ
15200	.....	A	Skin full graft	8.03	9.90	5.64	0.73	18.66	14.40	090
15201	.....	A	Skin full graft add-on	1.32	1.00	0.68	0.14	2.46	2.14	ZZZ
15220	.....	A	Skin full graft	7.87	9.38	6.47	0.68	17.93	15.02	090
15221	.....	A	Skin full graft add-on	1.19	0.92	0.60	0.12	2.23	1.91	ZZZ
15240	.....	A	Skin full graft	9.04	9.01	7.27	0.77	18.82	17.08	090
15241	.....	A	Skin full graft add-on	1.86	1.47	0.95	0.17	3.50	2.98	ZZZ
15260	.....	A	Skin full graft	10.06	9.01	7.74	0.63	19.70	18.43	090
15261	.....	A	Skin full graft add-on	2.23	1.59	1.16	0.17	3.99	3.56	ZZZ
15342	.....	A	Cultured skin graft, 25 cm	1.00	2.18	1.04	0.09	3.27	2.13	010
15343	.....	A	Cultured skin graft addl 25 cm	0.25	0.42	0.10	0.02	0.69	0.37	ZZZ
15350	.....	A	Skin homograft	4.00	7.78	4.23	0.42	12.20	8.65	090
15351	.....	A	Skin homograft add-on	1.00	0.85	0.42	0.11	1.96	1.53	ZZZ
15400	.....	A	Skin heterograft	4.00	4.89	4.89	0.40	9.29	9.29	090
15401	.....	A	Skin heterograft add-on	1.00	1.59	0.47	0.11	2.70	1.58	ZZZ
15570	.....	A	Form skin pedicle flap	9.21	7.80	6.37	0.96	17.97	16.54	090
15572	.....	A	Form skin pedicle flap	9.27	8.08	6.34	0.93	18.28	16.54	090
15574	.....	A	Form skin pedicle flap	9.88	8.61	7.14	0.92	19.41	17.94	090
15576	.....	A	Form skin pedicle flap	8.69	8.89	6.55	0.72	18.30	15.96	090
15600	.....	A	Skin graft	1.91	6.66	2.51	0.19	8.76	4.61	090
15610	.....	A	Skin graft	2.42	5.90	2.67	0.25	8.57	5.34	090
15620	.....	A	Skin graft	2.94	7.04	3.54	0.28	10.26	6.76	090
15630	.....	A	Skin graft	3.27	6.09	3.83	0.28	9.64	7.38	090
15650	.....	A	Transfer skin pedicle flap	3.97	5.69	3.99	0.36	10.02	8.32	090
15732	.....	A	Muscle-skin graft, head/neck	17.84	NA	11.63	1.50	NA	30.97	090
15734	.....	A	Muscle-skin graft, trunk	17.79	NA	11.49	1.91	NA	31.19	090
15736	.....	A	Muscle-skin graft, arm	16.27	NA	11.14	1.78	NA	29.19	090
15738	.....	A	Muscle-skin graft, leg	17.92	NA	11.47	1.95	NA	31.34	090
15740	.....	A	Island pedicle flap graft	10.25	8.74	7.20	0.62	19.61	18.07	090
15750	.....	A	Neurovascular pedicle graft	11.41	NA	8.45	1.12	NA	20.98	090
15756	.....	A	Free muscle flap, microvasc	35.23	NA	22.50	3.11	NA	60.84	090
15757	.....	A	Free skin flap, microvasc	35.23	NA	22.54	3.37	NA	61.14	090
15758	.....	A	Free fascial flap, microvasc	35.10	NA	22.75	3.52	NA	61.37	090
15760	.....	A	Composite skin graft	8.74	9.27	6.93	0.72	18.73	16.39	090
15770	.....	A	Derma-fat-fascia graft	7.52	NA	6.14	0.78	NA	14.44	090
15775	.....	R	Hair transplant punch grafts	3.96	3.12	1.60	0.43	7.51	5.99	000
15776	.....	R	Hair transplant punch grafts	5.54	3.97	2.97	0.60	10.11	9.11	000
15780	.....	A	Abrasion treatment of skin	7.29	6.41	6.13	0.41	14.11	13.83	090
15781	.....	A	Abrasion treatment of skin	4.85	5.17	4.83	0.27	10.29	9.95	090
15782	.....	A	Abrasion treatment of skin	4.32	4.37	4.09	0.21	8.90	8.62	090
15783	.....	A	Abrasion treatment of skin	4.29	5.02	3.51	0.26	9.57	8.06	090
15786	.....	A	Abrasion, lesion, single	2.03	1.73	1.29	0.11	3.87	3.43	010
15787	.....	A	Abrasion, lesions, add-on	0.33	0.39	0.18	0.02	0.74	0.53	ZZZ
15788	.....	R	Chemical peel, face, epiderm	2.09	3.15	1.07	0.11	5.35	3.27	090
15789	.....	R	Chemical peel, face, dermal	4.92	5.65	3.32	0.27	10.84	8.51	090
15792	.....	R	Chemical peel, nonfacial	1.86	2.87	1.63	0.10	4.83	3.59	090
15793	.....	A	Chemical peel, nonfacial	3.74	NA	3.81	0.17	NA	7.72	090
15810	.....	A	Salabrasion	4.74	4.04	4.04	0.42	9.20	9.20	090
15811	.....	A	Salabrasion	5.39	5.85	5.06	0.52	11.76	10.97	090
15819	.....	A	Plastic surgery, neck	9.38	NA	6.24	0.77	NA	16.39	090
15820	.....	A	Revision of lower eyelid	5.15	10.34	7.13	0.30	15.79	12.58	090
15821	.....	A	Revision of lower eyelid	5.72	11.87	7.34	0.31	17.90	13.37	090
15822	.....	A	Revision of upper eyelid	4.45	10.58	6.58	0.22	15.25	11.25	090
15823	.....	A	Revision of upper eyelid	7.05	11.38	7.60	0.32	18.75	14.97	090
15824	.....	R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825	.....	R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826	.....	R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828	.....	R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15831		A	Excise excessive skin tissue	12.40	NA	8.14	1.30	NA	21.84	090
15832		A	Excise excessive skin tissue	11.59	NA	8.04	1.21	NA	20.84	090
15833		A	Excise excessive skin tissue	10.64	NA	7.34	1.17	NA	19.15	090
15834		A	Excise excessive skin tissue	10.85	NA	7.59	1.18	NA	19.62	090
15835		A	Excise excessive skin tissue	11.67	NA	7.94	1.13	NA	20.74	090
15836		A	Excise excessive skin tissue	9.34	NA	6.51	0.95	NA	16.80	090
15837		A	Excise excessive skin tissue	8.43	7.30	6.38	0.78	16.51	15.59	090
15838		A	Excise excessive skin tissue	7.13	NA	5.70	0.58	NA	13.41	090
15839		A	Excise excessive skin tissue	9.38	7.64	5.97	0.88	17.90	16.23	090
15840		A	Graft for face nerve palsy	13.26	NA	10.10	1.15	NA	24.51	090
15841		A	Graft for face nerve palsy	23.26	NA	14.68	2.65	NA	40.59	090
15842		A	Flap for face nerve palsy	37.96	NA	22.81	3.99	NA	64.76	090
15845		A	Skin and muscle repair, face	12.57	NA	8.81	0.80	NA	22.18	090
15850		B	Removal of sutures	+0.78	1.43	0.31	0.04	2.25	1.13	XXX
15851		A	Removal of sutures	0.86	1.64	0.35	0.05	2.55	1.26	000
15852		A	Dressing change, not for burn	0.86	1.93	0.36	0.07	2.86	1.29	000
15860		A	Test for blood flow in graft	1.95	1.35	0.84	0.13	3.43	2.92	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	7.95	NA	5.90	0.83	NA	14.68	090
15922		A	Removal of tail bone ulcer	9.90	NA	7.78	1.06	NA	18.74	090
15931		A	Remove sacrum pressure sore	9.24	NA	5.89	0.95	NA	16.08	090
15933		A	Remove sacrum pressure sore	10.85	NA	8.32	1.14	NA	20.31	090
15934		A	Remove sacrum pressure sore	12.69	NA	8.48	1.35	NA	22.52	090
15935		A	Remove sacrum pressure sore	14.57	NA	10.12	1.56	NA	26.25	090
15936		A	Remove sacrum pressure sore	12.38	NA	8.81	1.32	NA	22.51	090
15937		A	Remove sacrum pressure sore	14.21	NA	10.75	1.51	NA	26.47	090
15940		A	Remove hip pressure sore	9.34	NA	6.17	0.98	NA	16.49	090
15941		A	Remove hip pressure sore	11.43	NA	10.44	1.23	NA	23.10	090
15944		A	Remove hip pressure sore	11.46	NA	8.77	1.21	NA	21.44	090
15945		A	Remove hip pressure sore	12.69	NA	9.73	1.38	NA	23.80	090
15946		A	Remove hip pressure sore	21.57	NA	14.65	2.32	NA	38.54	090
15950		A	Remove thigh pressure sore	7.54	NA	5.43	0.80	NA	13.77	090
15951		A	Remove thigh pressure sore	10.72	NA	8.07	1.14	NA	19.93	090
15952		A	Remove thigh pressure sore	11.39	NA	7.86	1.19	NA	20.44	090
15953		A	Remove thigh pressure sore	12.63	NA	9.24	1.38	NA	23.25	090
15956		A	Remove thigh pressure sore	15.52	NA	10.71	1.64	NA	27.87	090
15958		A	Remove thigh pressure sore	15.48	NA	11.20	1.66	NA	28.34	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	1.09	0.27	0.06	2.04	1.22	000
16010		A	Treatment of burn(s)	0.87	1.21	0.37	0.07	2.15	1.31	000
16015		A	Treatment of burn(s)	2.35	2.01	1.03	0.22	4.58	3.60	000
16020		A	Treatment of burn(s)	0.80	1.20	0.27	0.06	2.06	1.13	000
16025		A	Treatment of burn(s)	1.85	1.94	0.69	0.16	3.95	2.70	000
16030		A	Treatment of burn(s)	2.08	3.36	0.97	0.18	5.62	3.23	000
16035		A	Incision of burn scab, initi	3.75	NA	1.56	0.36	NA	5.67	090
16036		A	Incise burn scab, addl incis	1.50	NA	0.62	0.11	NA	2.23	ZZZ
17000		A	Detroy benign/premal lesion	0.60	1.10	0.28	0.03	1.73	0.91	010
17003		A	Destroy lesions, 2–14	0.15	0.24	0.07	0.01	0.40	0.23	ZZZ
17004		A	Destroy lesions, 15 or more	2.79	2.56	1.30	0.12	5.47	4.21	010
17106		A	Destruction of skin lesions	4.59	4.88	2.88	0.28	9.75	7.75	090
17107		A	Destruction of skin lesions	9.16	6.92	5.28	0.53	16.61	14.97	090
17108		A	Destruction of skin lesions	13.20	8.87	7.26	0.89	22.96	21.35	090
17110		A	Destruct lesion, 1–14	0.65	1.11	0.26	0.04	1.80	0.95	010
17111		A	Destruct lesion, 15 or more	0.92	1.13	0.41	0.04	2.09	1.37	010
17250		A	Chemical cautery, tissue	0.50	0.76	0.21	0.04	1.30	0.75	000
17260		A	Destruction of skin lesions	0.91	1.37	0.39	0.04	2.32	1.34	010
17261		A	Destruction of skin lesions	1.17	1.48	0.56	0.05	2.70	1.78	010
17262		A	Destruction of skin lesions	1.58	1.69	0.76	0.07	3.34	2.41	010
17263		A	Destruction of skin lesions	1.79	1.80	0.83	0.08	3.67	2.70	010
17264		A	Destruction of skin lesions	1.94	1.87	0.87	0.08	3.89	2.89	010
17266		A	Destruction of skin lesions	2.34	2.08	1.05	0.11	4.53	3.50	010
17270		A	Destruction of skin lesions	1.32	1.57	0.60	0.06	2.95	1.98	010
17271		A	Destruction of skin lesions	1.49	1.65	0.72	0.06	3.20	2.27	010
17272		A	Destruction of skin lesions	1.77	1.79	0.86	0.07	3.63	2.70	010
17273		A	Destruction of skin lesions	2.05	1.93	0.97	0.09	4.07	3.11	010
17274		A	Destruction of skin lesions	2.59	2.21	1.20	0.11	4.91	3.90	010
17276		A	Destruction of skin lesions	3.20	2.52	1.84	0.15	5.87	5.19	010
17280		A	Destruction of skin lesions	1.17	1.41	0.54	0.05	2.63	1.76	010
17281		A	Destruction of skin lesions	1.72	1.77	0.83	0.07	3.56	2.62	010

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
17282	.....	A	Destruction of skin lesions	2.04	1.93	0.99	0.09	4.06	3.12	010
17283	.....	A	Destruction of skin lesions	2.64	2.23	1.24	0.11	4.98	3.99	010
17284	.....	A	Destruction of skin lesions	3.21	2.52	1.51	0.14	5.87	4.86	010
17286	.....	A	Destruction of skin lesions	4.44	3.23	2.52	0.22	7.89	7.18	010
17304	.....	A	Chemosurgery of skin lesion	7.60	7.76	3.74	0.31	15.67	11.65	000
17305	.....	A	2nd stage chemosurgery	2.85	3.60	1.40	0.12	6.57	4.37	000
17306	.....	A	3rd stage chemosurgery	2.85	3.64	1.41	0.12	6.61	4.38	000
17307	.....	A	Followup skin lesion therapy	2.85	3.62	1.43	0.12	6.59	4.40	000
17310	.....	A	Extensive skin chemosurgery	0.95	1.54	0.48	0.05	2.54	1.48	000
17340	.....	A	Cryotherapy of skin	0.76	0.39	0.27	0.04	1.19	1.07	010
17360	.....	A	Skin peel therapy	1.43	1.46	0.73	0.06	2.95	2.22	010
17380	.....	R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999	.....	C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000	.....	A	Drainage of breast lesion	0.84	1.27	0.30	0.07	2.18	1.21	000
19001	.....	A	Drain breast lesion add-on	0.42	0.86	0.15	0.03	1.31	0.60	ZZZ
19020	.....	A	Incision of breast lesion	3.57	7.13	3.51	0.35	11.05	7.43	090
19030	.....	A	Injection for breast x-ray	1.53	3.70	0.54	0.07	5.30	2.14	000
19100	.....	A	Bx breast percut w/o image	1.27	1.50	0.45	0.10	2.87	1.82	000
19101	.....	A	Biopsy of breast, open	3.18	5.27	1.97	0.20	8.65	5.35	010
19102	.....	A	Bx breast percut w/image	2.00	5.13	0.71	0.13	7.26	2.84	000
19103	.....	A	Bx breast percut w/device	3.70	12.73	1.31	0.16	16.59	5.17	000
19110	.....	A	Nipple exploration	4.30	9.79	4.56	0.44	14.53	9.30	090
19112	.....	A	Excise breast duct fistula	3.67	10.91	3.19	0.38	14.96	7.24	090
19120	.....	A	Removal of breast lesion	5.56	5.18	3.20	0.56	11.30	9.32	090
19125	.....	A	Excision, breast lesion	6.06	5.36	3.36	0.61	12.03	10.03	090
19126	.....	A	Excision, addl breast lesion	2.93	NA	1.06	0.30	NA	4.29	ZZZ
19140	.....	A	Removal of breast tissue	5.14	10.26	3.79	0.52	15.92	9.45	090
19160	.....	A	Removal of breast tissue	5.99	NA	4.62	0.61	NA	11.22	090
19162	.....	A	Remove breast tissue, nodes	13.53	NA	8.07	1.38	NA	22.98	090
19180	.....	A	Removal of breast	8.80	NA	6.08	0.88	NA	15.76	090
19182	.....	A	Removal of breast	7.73	NA	5.06	0.79	NA	13.58	090
19200	.....	A	Removal of breast	15.49	NA	9.33	1.51	NA	26.33	090
19220	.....	A	Removal of breast	15.72	NA	9.52	1.56	NA	26.80	090
19240	.....	A	Removal of breast	16.00	NA	8.94	1.62	NA	26.56	090
19260	.....	A	Removal of chest wall lesion	15.44	NA	9.12	1.64	NA	26.20	090
19271	.....	A	Revision of chest wall	18.90	NA	11.13	2.27	NA	32.30	090
19272	.....	A	Extensive chest wall surgery	21.55	NA	12.36	2.54	NA	36.45	090
19290	.....	A	Place needle wire, breast	1.27	2.95	0.45	0.06	4.28	1.78	000
19291	.....	A	Place needle wire, breast	0.63	1.74	0.22	0.03	2.40	0.88	ZZZ
19295	.....	A	Place breast clip, percut	0.00	2.83	NA	0.01	2.84	NA	ZZZ
19316	.....	A	Suspension of breast	10.69	NA	8.00	1.15	NA	19.84	090
19318	.....	A	Reduction of large breast	15.62	NA	10.64	1.69	NA	27.95	090
19324	.....	A	Enlarge breast	5.85	NA	4.41	0.63	NA	10.89	090
19325	.....	A	Enlarge breast with implant	8.45	NA	7.00	0.90	NA	16.35	090
19328	.....	A	Removal of breast implant	5.68	NA	4.73	0.61	NA	11.02	090
19330	.....	A	Removal of implant material	7.59	NA	5.41	0.81	NA	13.81	090
19340	.....	A	Immediate breast prosthesis	6.33	NA	3.30	0.68	NA	10.31	ZZZ
19342	.....	A	Delayed breast prosthesis	11.20	NA	8.15	1.21	NA	20.56	090
19350	.....	A	Breast reconstruction	8.92	14.55	7.09	0.95	24.42	16.96	090
19355	.....	A	Correct inverted nipple(s)	7.57	12.42	5.93	0.80	20.79	14.30	090
19357	.....	A	Breast reconstruction	18.16	NA	14.40	1.96	NA	34.52	090
19361	.....	A	Breast reconstruction	19.26	NA	12.45	2.08	NA	33.79	090
19364	.....	A	Breast reconstruction	41.00	NA	25.45	3.91	NA	70.36	090
19366	.....	A	Breast reconstruction	21.28	NA	12.02	2.27	NA	35.57	090
19367	.....	A	Breast reconstruction	25.73	NA	15.77	2.78	NA	44.28	090
19368	.....	A	Breast reconstruction	32.42	NA	19.04	3.51	NA	54.97	090
19369	.....	A	Breast reconstruction	29.82	NA	18.29	3.24	NA	51.35	090
19370	.....	A	Surgery of breast capsule	8.05	NA	6.39	0.86	NA	15.30	090
19371	.....	A	Removal of breast capsule	9.35	NA	7.46	1.01	NA	17.82	090
19380	.....	A	Revise breast reconstruction	9.14	NA	7.35	0.98	NA	17.47	090
19396	.....	A	Design custom breast implant	2.17	7.08	0.87	0.23	9.48	3.27	000
19499	.....	C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000	.....	A	Incision of abscess	2.12	2.23	1.20	0.17	4.52	3.49	010
20005	.....	A	Incision of deep abscess	3.42	3.07	2.22	0.34	6.83	5.98	010
20100	.....	A	Explore wound, neck	10.08	6.49	4.12	0.99	17.56	15.19	010
20101	.....	A	Explore wound, chest	3.22	3.03	1.64	0.24	6.49	5.10	010
20102	.....	A	Explore wound, abdomen	3.94	3.43	1.85	0.35	7.72	6.14	010
20103	.....	A	Explore wound, extremity	5.30	4.41	3.01	0.57	10.28	8.88	010
20150	.....	A	Excise epiphyseal bar	13.69	NA	9.72	0.96	NA	24.37	090
20200	.....	A	Muscle biopsy	1.46	1.72	0.62	0.17	3.35	2.25	000
20205	.....	A	Deep muscle biopsy	2.35	4.04	0.98	0.23	6.62	3.56	000
20206	.....	A	Needle biopsy, muscle	0.99	3.27	0.36	0.06	4.32	1.41	000
20220	.....	A	Bone biopsy, trocar/needle	1.27	4.96	2.98	0.06	6.29	4.31	000

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
20225	.....	A	Bone biopsy, trocar/needle	1.87	4.47	3.06	0.11	6.45	5.04	000
20240	.....	A	Bone biopsy, excisional	3.23	NA	4.15	0.33	NA	7.71	010
20245	.....	A	Bone biopsy, excisional	7.78	NA	6.91	0.44	NA	15.13	010
20250	.....	A	Open bone biopsy	5.03	NA	4.37	0.50	NA	9.90	010
20251	.....	A	Open bone biopsy	5.56	NA	4.86	0.79	NA	11.21	010
20500	.....	A	Injection of sinus tract	1.23	5.34	3.91	0.10	6.67	5.24	010
20501	.....	A	Inject sinus tract for x-ray	0.76	3.32	0.27	0.03	4.11	1.06	000
20520	.....	A	Removal of foreign body	1.85	5.62	3.62	0.17	7.64	5.64	010
20525	.....	A	Removal of foreign body	3.50	7.26	4.40	0.40	11.16	8.30	010
20526	.....	A	Ther injection carpal tunnel	0.86	0.78	0.39	0.06	1.70	1.31	000
20550	.....	A	Inject tendon/ligament/cyst	0.86	0.85	0.28	0.06	1.77	1.20	000
20551	.....	A	Inject tendon origin/insert	0.86	0.78	0.39	0.06	1.70	1.31	000
20552	.....	A	Inject trigger point, 1 or 2	0.86	0.78	0.39	0.06	1.70	1.31	000
20553	.....	A	Inject trigger points, > 3	0.86	0.78	0.39	0.06	1.70	1.31	000
20600	.....	A	Drain/inject, joint/bursa	0.66	0.67	0.37	0.06	1.39	1.09	000
20605	.....	A	Drain/inject, joint/bursa	0.68	0.78	0.38	0.06	1.52	1.12	000
20610	.....	A	Drain/inject, joint/bursa	0.79	0.96	0.44	0.08	1.83	1.31	000
20615	.....	A	Treatment of bone cyst	2.28	4.89	2.52	0.19	7.36	4.99	010
20650	.....	A	Insert and remove bone pin	2.23	5.06	3.19	0.28	7.57	5.70	010
20660	.....	A	Apply, remove fixation device	2.51	NA	1.49	0.48	NA	4.48	000
20661	.....	A	Application of head brace	4.89	NA	6.74	0.92	NA	12.55	090
20662	.....	A	Application of pelvis brace	6.07	NA	5.12	0.81	NA	12.00	090
20663	.....	A	Application of thigh brace	5.43	NA	4.94	0.77	NA	11.14	090
20664	.....	A	Halo brace application	8.06	NA	8.55	1.49	NA	18.10	090
20665	.....	A	Removal of fixation device	1.31	2.33	1.25	0.17	3.81	2.73	010
20670	.....	A	Removal of support implant	1.74	5.73	3.42	0.23	7.70	5.39	010
20680	.....	A	Removal of support implant	3.35	5.04	5.04	0.46	8.85	8.85	090
20690	.....	A	Apply bone fixation device	3.52	NA	1.91	0.47	NA	5.90	090
20692	.....	A	Apply bone fixation device	6.41	NA	3.57	0.60	NA	10.58	090
20693	.....	A	Adjust bone fixation device	5.86	NA	12.98	0.85	NA	19.69	090
20694	.....	A	Remove bone fixation device	4.16	8.96	6.30	0.57	13.69	11.03	090
20802	.....	A	Replantation, arm, complete	41.15	NA	28.95	5.81	NA	75.91	090
20805	.....	A	Replant, forearm, complete	50.00	NA	38.72	3.95	NA	92.67	090
20808	.....	A	Replantation hand, complete	61.65	NA	56.41	6.49	NA	124.55	090
20816	.....	A	Replantation digit, complete	30.94	NA	49.50	3.01	NA	83.45	090
20822	.....	A	Replantation digit, complete	25.59	NA	45.97	3.07	NA	74.63	090
20824	.....	A	Replantation thumb, complete	30.94	NA	49.10	3.48	NA	83.52	090
20827	.....	A	Replantation thumb, complete	26.41	NA	45.65	3.21	NA	75.27	090
20838	.....	A	Replantation foot, complete	41.41	NA	25.82	5.85	NA	73.08	090
20900	.....	A	Removal of bone for graft	5.58	5.97	5.97	0.77	12.32	12.32	090
20902	.....	A	Removal of bone for graft	7.55	NA	8.91	1.06	NA	17.52	090
20910	.....	A	Remove cartilage for graft	5.34	9.09	6.94	0.50	14.93	12.78	090
20912	.....	A	Remove cartilage for graft	6.35	NA	7.68	0.55	NA	14.58	090
20920	.....	A	Removal of fascia for graft	5.31	NA	5.44	0.54	NA	11.29	090
20922	.....	A	Removal of fascia for graft	6.61	8.50	6.28	0.88	15.99	13.77	090
20924	.....	A	Removal of tendon for graft	6.48	NA	7.03	0.82	NA	14.33	090
20926	.....	A	Removal of tissue for graft	5.53	NA	6.54	0.73	NA	12.80	090
20930	.....	B	Spinal bone allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931	.....	A	Spinal bone allograft	1.81	NA	0.98	0.34	NA	3.13	ZZZ
20936	.....	B	Spinal bone autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937	.....	A	Spinal bone autograft	2.79	NA	1.54	0.43	NA	4.76	ZZZ
20938	.....	A	Spinal bone autograft	3.02	NA	1.64	0.52	NA	5.18	ZZZ
20950	.....	A	Fluid pressure, muscle	1.26	NA	2.15	0.16	NA	3.57	000
20955	.....	A	Fibula bone graft, microvasc	39.21	NA	30.52	4.35	NA	74.08	090
20956	.....	A	Iliac bone graft, microvasc	39.27	NA	28.18	5.77	NA	73.22	090
20957	.....	A	Mt bone graft, microvasc	40.65	NA	21.71	5.74	NA	68.10	090
20962	.....	A	Other bone graft, microvasc	39.27	NA	28.54	5.19	NA	73.00	090
20969	.....	A	Bone/skin graft, microvasc	43.92	NA	33.31	4.34	NA	81.57	090
20970	.....	A	Bone/skin graft, iliac crest	43.06	NA	30.08	4.64	NA	77.78	090
20972	.....	A	Bone/skin graft, metatarsal	42.99	NA	18.23	6.07	NA	67.29	090
20973	.....	A	Bone/skin graft, great toe	45.76	NA	30.52	4.65	NA	80.93	090
20974	.....	A	Electrical bone stimulation	0.62	0.47	0.34	0.09	1.18	1.05	000
20975	.....	A	Electrical bone stimulation	2.60	NA	1.42	0.42	NA	4.44	000
20979	.....	A	Us bone stimulation	0.62	0.58	0.25	0.04	1.24	0.91	000
20999	.....	C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010	.....	A	Incision of jaw joint	10.14	NA	7.24	0.54	NA	17.92	090
21015	.....	A	Resection of facial tumor	5.29	NA	7.38	0.52	NA	13.19	090
21025	.....	A	Excision of bone, lower jaw	10.06	7.40	7.00	0.79	18.25	17.85	090
21026	.....	A	Excision of facial bone(s)	4.85	5.23	5.12	0.40	10.48	10.37	090
21029	.....	A	Contour of face bone lesion	7.71	7.18	6.73	0.74	15.63	15.18	090
21030	.....	A	Removal of face bone lesion	6.46	5.47	4.94	0.60	12.53	12.00	090
21031	.....	A	Remove exostosis, mandible	3.24	3.39	2.19	0.28	6.91	5.71	090
21032	.....	A	Remove exostosis, maxilla	3.24	3.38	2.47	0.27	6.89	5.98	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
21034		A	Removal of face bone lesion	16.17	10.59	10.59	1.37	28.13	28.13	090
21040		A	Removal of jaw bone lesion	2.11	3.03	1.81	0.19	5.33	4.11	090
21041		A	Removal of jaw bone lesion	6.71	5.68	4.46	0.56	12.95	11.73	090
21044		A	Removal of jaw bone lesion	11.86	NA	8.33	0.87	NA	21.06	090
21045		A	Extensive jaw surgery	16.17	NA	10.63	1.20	NA	28.00	090
21050		A	Removal of jaw joint	10.77	NA	11.93	0.84	NA	23.54	090
21060		A	Remove jaw joint cartilage	10.23	NA	10.59	1.16	NA	21.98	090
21070		A	Remove coronoid process	8.20	NA	6.36	0.67	NA	15.23	090
21076		A	Prepare face/oral prosthesis	13.42	9.87	7.41	1.36	24.65	22.19	010
21077		A	Prepare face/oral prosthesis	33.75	24.83	18.64	3.43	62.01	55.82	090
21079		A	Prepare face/oral prosthesis	22.34	17.55	12.90	1.59	41.48	36.83	090
21080		A	Prepare face/oral prosthesis	25.10	19.72	14.49	2.55	47.37	42.14	090
21081		A	Prepare face/oral prosthesis	22.88	17.97	13.21	1.87	42.72	37.96	090
21082		A	Prepare face/oral prosthesis	20.87	15.35	11.53	1.46	37.68	33.86	090
21083		A	Prepare face/oral prosthesis	19.30	15.16	11.14	1.96	36.42	32.40	090
21084		A	Prepare face/oral prosthesis	22.51	17.68	12.99	1.57	41.76	37.07	090
21085		A	Prepare face/oral prosthesis	9.00	6.62	4.97	0.65	16.27	14.62	010
21086		A	Prepare face/oral prosthesis	24.92	19.58	14.39	1.86	46.36	41.17	090
21087		A	Prepare face/oral prosthesis	24.92	18.33	13.76	2.22	45.47	40.90	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21100		A	Maxillofacial fixation	4.22	5.66	3.70	0.18	10.06	8.10	090
21110		A	Interdental fixation	5.21	5.25	4.48	0.28	10.74	9.97	090
21116		A	Injection, jaw joint x-ray	0.81	7.88	0.30	0.05	8.74	1.16	000
21120		A	Reconstruction of chin	4.93	7.96	4.98	0.29	13.18	10.20	090
21121		A	Reconstruction of chin	7.64	7.68	6.65	0.56	15.88	14.85	090
21122		A	Reconstruction of chin	8.52	NA	7.95	0.59	NA	17.06	090
21123		A	Reconstruction of chin	11.16	NA	7.68	1.16	NA	20.00	090
21125		A	Augmentation, lower jaw bone	10.62	9.56	7.84	0.72	20.90	19.18	090
21127		A	Augmentation, lower jaw bone	11.12	10.66	7.33	0.76	22.54	19.21	090
21137		A	Reduction of forehead	9.82	NA	8.20	0.53	NA	18.55	090
21138		A	Reduction of forehead	12.19	NA	8.82	1.47	NA	22.48	090
21139		A	Reduction of forehead	14.61	NA	8.23	1.02	NA	23.86	090
21141		A	Reconstruct midface, lefort	18.10	NA	10.69	1.63	NA	30.42	090
21142		A	Reconstruct midface, lefort	18.81	NA	13.80	1.16	NA	33.77	090
21143		A	Reconstruct midface, lefort	19.58	NA	11.21	0.90	NA	31.69	090
21145		A	Reconstruct midface, lefort	19.94	NA	11.69	2.09	NA	33.72	090
21146		A	Reconstruct midface, lefort	20.71	NA	11.61	2.13	NA	34.45	090
21147		A	Reconstruct midface, lefort	21.77	NA	12.07	1.52	NA	35.36	090
21150		A	Reconstruct midface, lefort	25.24	NA	17.20	1.09	NA	43.53	090
21151		A	Reconstruct midface, lefort	28.30	NA	21.35	1.98	NA	51.63	090
21154		A	Reconstruct midface, lefort	30.52	NA	21.03	4.86	NA	56.41	090
21155		A	Reconstruct midface, lefort	34.45	NA	23.20	5.48	NA	63.13	090
21159		A	Reconstruct midface, lefort	42.38	NA	21.72	6.74	NA	70.84	090
21160		A	Reconstruct midface, lefort	46.44	NA	30.39	4.39	NA	81.22	090
21172		A	Reconstruct orbit/forehead	27.80	NA	16.39	1.91	NA	46.10	090
21175		A	Reconstruct orbit/forehead	33.17	NA	19.79	5.16	NA	58.12	090
21179		A	Reconstruct entire forehead	22.25	NA	18.94	2.48	NA	43.67	090
21180		A	Reconstruct entire forehead	25.19	NA	18.33	2.15	NA	45.67	090
21181		A	Contour cranial bone lesion	9.90	NA	8.46	0.97	NA	19.33	090
21182		A	Reconstruct cranial bone	32.19	NA	21.97	2.53	NA	56.69	090
21183		A	Reconstruct cranial bone	35.31	NA	22.93	2.75	NA	60.99	090
21184		A	Reconstruct cranial bone	38.24	NA	19.54	4.12	NA	61.90	090
21188		A	Reconstruction of midface	22.46	NA	15.86	1.85	NA	40.17	090
21193		A	Reconst lwr jaw w/o graft	17.15	NA	10.77	1.53	NA	29.45	090
21194		A	Reconst lwr jaw w/graft	19.84	NA	12.44	1.39	NA	33.67	090
21195		A	Reconst lwr jaw w/o fixation	17.24	NA	12.36	1.20	NA	30.80	090
21196		A	Reconst lwr jaw w/fixation	18.91	NA	12.83	1.62	NA	33.36	090
21198		A	Reconstr lwr jaw segment	14.16	NA	12.30	1.05	NA	27.51	090
21199		A	Reconstr lwr jaw w/advance	16.00	NA	10.85	1.26	NA	28.11	090
21206		A	Reconstruct upper jaw bone	14.10	NA	9.39	1.01	NA	24.50	090
21208		A	Augmentation of facial bones	10.23	8.95	8.62	0.92	20.10	19.77	090
21209		A	Reduction of facial bones	6.72	8.05	6.54	0.60	15.37	13.86	090
21210		A	Face bone graft	10.23	8.82	8.28	0.88	19.93	19.39	090
21215		A	Lower jaw bone graft	10.77	8.95	7.48	1.04	20.76	19.29	090
21230		A	Rib cartilage graft	10.77	NA	10.85	0.96	NA	22.58	090
21235		A	Ear cartilage graft	6.72	11.90	8.36	0.52	19.14	15.60	090
21240		A	Reconstruction of jaw joint	14.05	NA	11.79	1.15	NA	26.99	090
21242		A	Reconstruction of jaw joint	12.95	NA	10.85	1.40	NA	25.20	090
21243		A	Reconstruction of jaw joint	20.79	NA	13.97	1.85	NA	36.61	090
21244		A	Reconstruction of lower jaw	11.86	NA	9.56	0.95	NA	22.37	090
21245		A	Reconstruction of jaw	11.86	24.85	10.25	0.88	37.59	22.99	090
21246		A	Reconstruction of jaw	12.47	10.20	10.20	1.21	23.88	23.88	090

[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
21247		A	Reconstruct lower jaw bone	22.63	NA	20.17	2.21	NA	45.01	090
21248		A	Reconstruction of jaw	11.48	8.91	7.86	1.01	21.40	20.35	090
21249		A	Reconstruction of jaw	17.52	11.44	10.35	1.39	30.35	29.26	090
21255		A	Reconstruct lower jaw bone	16.72	NA	13.16	1.13	NA	31.01	090
21256		A	Reconstruction of orbit	16.19	NA	13.87	1.04	NA	31.10	090
21260		A	Revise eye sockets	16.52	NA	13.54	1.25	NA	31.31	090
21261		A	Revise eye sockets	31.49	NA	20.04	2.20	NA	53.73	090
21263		A	Revise eye sockets	28.42	NA	15.09	2.16	NA	45.67	090
21267		A	Revise eye sockets	18.90	NA	14.75	1.35	NA	35.00	090
21268		A	Revise eye sockets	24.48	NA	15.15	0.79	NA	40.42	090
21270		A	Augmentation, cheek bone	10.23	10.39	9.99	0.73	21.35	20.95	090
21275		A	Revision, orbitofacial bones	11.24	NA	11.02	1.03	NA	23.29	090
21280		A	Revision of eyelid	6.03	NA	6.27	0.27	NA	12.57	090
21282		A	Revision of eyelid	3.49	NA	5.38	0.21	NA	9.08	090
21295		A	Revision of jaw muscle/bone	1.53	NA	4.34	0.13	NA	6.00	090
21296		A	Revision of jaw muscle/bone	4.25	NA	4.09	0.30	NA	8.64	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21300		A	Treatment of skull fracture	0.72	2.77	0.30	0.09	3.58	1.11	000
21310		A	Treatment of nose fracture	0.58	2.70	0.15	0.05	3.33	0.78	000
21315		A	Treatment of nose fracture	1.51	3.49	1.27	0.12	5.12	2.90	010
21320		A	Treatment of nose fracture	1.85	4.96	2.10	0.15	6.96	4.10	010
21325		A	Treatment of nose fracture	3.77	NA	3.73	0.31	NA	7.81	090
21330		A	Treatment of nose fracture	5.38	NA	5.67	0.48	NA	11.53	090
21335		A	Treatment of nose fracture	8.61	NA	7.34	0.64	NA	16.59	090
21336		A	Treat nasal septal fracture	5.72	NA	5.74	0.45	NA	11.91	090
21337		A	Treat nasal septal fracture	2.70	5.24	3.42	0.22	8.16	6.34	090
21338		A	Treat nasoethmoid fracture	6.46	NA	5.75	0.53	NA	12.74	090
21339		A	Treat nasoethmoid fracture	8.09	NA	6.97	0.76	NA	15.82	090
21340		A	Treatment of nose fracture	10.77	NA	8.78	0.85	NA	20.40	090
21343		A	Treatment of sinus fracture	12.95	NA	9.48	1.06	NA	23.49	090
21344		A	Treatment of sinus fracture	19.72	NA	13.82	1.72	NA	35.26	090
21345		A	Treat nose/jaw fracture	8.16	10.36	7.91	0.60	19.12	16.67	090
21346		A	Treat nose/jaw fracture	10.61	NA	10.12	0.85	NA	21.58	090
21347		A	Treat nose/jaw fracture	12.69	NA	9.68	1.14	NA	23.51	090
21348		A	Treat nose/jaw fracture	16.69	NA	11.57	1.50	NA	29.76	090
21355		A	Treat cheek bone fracture	3.77	3.89	2.54	0.29	7.95	6.60	010
21356		A	Treat cheek bone fracture	4.15	NA	3.31	0.36	NA	7.82	010
21360		A	Treat cheek bone fracture	6.46	NA	5.74	0.52	NA	12.72	090
21365		A	Treat cheek bone fracture	14.95	NA	11.72	1.30	NA	27.97	090
21366		A	Treat cheek bone fracture	17.77	NA	14.28	1.41	NA	33.46	090
21385		A	Treat eye socket fracture	9.16	NA	8.04	0.64	NA	17.84	090
21386		A	Treat eye socket fracture	9.16	NA	8.43	0.76	NA	18.35	090
21387		A	Treat eye socket fracture	9.70	NA	8.55	0.78	NA	19.03	090
21390		A	Treat eye socket fracture	10.13	NA	8.73	0.70	NA	19.56	090
21395		A	Treat eye socket fracture	12.68	NA	9.24	1.09	NA	23.01	090
21400		A	Treat eye socket fracture	1.40	3.29	1.05	0.12	4.81	2.57	090
21401		A	Treat eye socket fracture	3.26	4.34	3.65	0.34	7.94	7.25	090
21406		A	Treat eye socket fracture	7.01	NA	7.20	0.59	NA	14.80	090
21407		A	Treat eye socket fracture	8.61	NA	7.99	0.67	NA	17.27	090
21408		A	Treat eye socket fracture	12.38	NA	10.29	1.24	NA	23.91	090
21421		A	Treat mouth roof fracture	5.14	7.23	6.84	0.42	12.79	12.40	090
21422		A	Treat mouth roof fracture	8.32	NA	7.93	0.69	NA	16.94	090
21423		A	Treat mouth roof fracture	10.40	NA	8.63	0.95	NA	19.98	090
21431		A	Treat craniofacial fracture	7.05	NA	8.44	0.58	NA	16.07	090
21432		A	Treat craniofacial fracture	8.61	NA	8.06	0.55	NA	17.22	090
21433		A	Treat craniofacial fracture	25.35	NA	17.29	2.46	NA	45.10	090
21435		A	Treat craniofacial fracture	17.25	NA	12.97	1.66	NA	31.88	090
21436		A	Treat craniofacial fracture	28.04	NA	16.02	2.32	NA	46.38	090
21440		A	Treat dental ridge fracture	2.70	5.44	3.73	0.22	8.36	6.65	090
21445		A	Treat dental ridge fracture	5.38	7.14	5.04	0.55	13.07	10.97	090
21450		A	Treat lower jaw fracture	2.97	6.45	2.90	0.23	9.65	6.10	090
21451		A	Treat lower jaw fracture	4.87	6.46	6.11	0.39	11.72	11.37	090
21452		A	Treat lower jaw fracture	1.98	13.44	4.35	0.14	15.56	6.47	090
21453		A	Treat lower jaw fracture	5.54	7.32	6.69	0.49	13.35	12.72	090
21454		A	Treat lower jaw fracture	6.46	NA	5.72	0.55	NA	12.73	090
21461		A	Treat lower jaw fracture	8.09	8.40	8.26	0.73	17.22	17.08	090
21462		A	Treat lower jaw fracture	9.79	10.06	8.18	0.80	20.65	18.77	090
21465		A	Treat lower jaw fracture	11.91	NA	8.42	0.84	NA	21.17	090
21470		A	Treat lower jaw fracture	15.34	NA	10.31	1.36	NA	27.01	090
21480		A	Reset dislocated jaw	0.61	1.62	0.18	0.05	2.28	0.84	000
21485		A	Reset dislocated jaw	3.99	3.82	3.34	0.31	8.12	7.64	090
21490		A	Repair dislocated jaw	11.86	NA	7.69	1.31	NA	20.86	090
21493		A	Treat hyoid bone fracture	1.27	NA	3.68	0.10	NA	5.05	090

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
21494	.....	A	Treat hyoid bone fracture	6.28	NA	4.21	0.44	NA	10.93	090
21495	.....	A	Treat hyoid bone fracture	5.69	NA	5.28	0.41	NA	11.38	090
21497	.....	A	Interdental wiring	3.86	4.68	3.81	0.31	8.85	7.98	090
21499	.....	C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501	.....	A	Drain neck/chest lesion	3.81	4.50	3.64	0.36	8.67	7.81	090
21502	.....	A	Drain chest lesion	7.12	NA	7.05	0.79	NA	14.96	090
21510	.....	A	Drainage of bone lesion	5.74	NA	7.47	0.67	NA	13.88	090
21550	.....	A	Biopsy of neck/chest	2.06	2.32	1.25	0.13	4.51	3.44	010
21555	.....	A	Remove lesion, neck/chest	4.35	4.25	2.43	0.41	9.01	7.19	090
21556	.....	A	Remove lesion, neck/chest	5.57	NA	3.29	0.51	NA	9.37	090
21557	.....	A	Remove tumor, neck/chest	8.88	NA	7.87	0.85	NA	17.60	090
21600	.....	A	Partial removal of rib	6.89	NA	7.80	0.81	NA	15.50	090
21610	.....	A	Partial removal of rib	14.61	NA	11.26	1.85	NA	27.72	090
21615	.....	A	Removal of rib	9.87	NA	7.90	1.20	NA	18.97	090
21616	.....	A	Removal of rib and nerves	12.04	NA	8.94	1.31	NA	22.29	090
21620	.....	A	Partial removal of sternum	6.79	NA	8.13	0.77	NA	15.69	090
21627	.....	A	Sternal debridement	6.81	NA	12.16	0.82	NA	19.79	090
21630	.....	A	Extensive sternum surgery	17.38	NA	14.03	1.95	NA	33.36	090
21632	.....	A	Extensive sternum surgery	18.14	NA	12.35	2.16	NA	32.65	090
21700	.....	A	Revision of neck muscle	6.19	8.63	7.19	0.31	15.13	13.69	090
21705	.....	A	Revision of neck muscle/rib	9.60	NA	7.87	0.92	NA	18.39	090
21720	.....	A	Revision of neck muscle	5.68	8.71	5.93	0.80	15.19	12.41	090
21725	.....	A	Revision of neck muscle	6.99	NA	7.28	0.90	NA	15.17	090
21740	.....	A	Reconstruction of sternum	16.50	NA	12.85	2.03	NA	31.38	090
21750	.....	A	Repair of sternum separation	10.77	NA	9.41	1.35	NA	21.53	090
21800	.....	A	Treatment of rib fracture	0.96	2.31	1.11	0.09	3.36	2.16	090
21805	.....	A	Treatment of rib fracture	2.75	NA	4.08	0.29	NA	7.12	090
21810	.....	A	Treatment of rib fracture(s)	6.86	NA	7.49	0.60	NA	14.95	090
21820	.....	A	Treat sternum fracture	1.28	2.80	1.58	0.15	4.23	3.01	090
21825	.....	A	Treat sternum fracture	7.41	NA	9.90	0.84	NA	18.15	090
21899	.....	C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920	.....	A	Biopsy soft tissue of back	2.06	2.40	0.77	0.12	4.58	2.95	010
21925	.....	A	Biopsy soft tissue of back	4.49	10.19	4.79	0.44	15.12	9.72	090
21930	.....	A	Remove lesion, back or flank	5.00	4.55	2.66	0.49	10.04	8.15	090
21935	.....	A	Remove tumor, back	17.96	NA	13.53	1.87	NA	33.36	090
22100	.....	A	Remove part of neck vertebra	9.73	NA	8.36	1.55	NA	19.64	090
22101	.....	A	Remove part, thorax vertebra	9.81	NA	9.04	1.51	NA	20.36	090
22102	.....	A	Remove part, lumbar vertebra	9.81	NA	9.18	1.46	NA	20.45	090
22103	.....	A	Remove extra spine segment	2.34	NA	1.27	0.37	NA	3.98	ZZZ
22110	.....	A	Remove part of neck vertebra	12.74	NA	11.06	2.20	NA	26.00	090
22112	.....	A	Remove part, thorax vertebra	12.81	NA	10.95	1.96	NA	25.72	090
22114	.....	A	Remove part, lumbar vertebra	12.81	NA	10.71	1.98	NA	25.50	090
22116	.....	A	Remove extra spine segment	2.32	NA	1.26	0.40	NA	3.98	ZZZ
22210	.....	A	Revision of neck spine	23.82	NA	17.42	4.23	NA	45.47	090
22212	.....	A	Revision of thorax spine	19.42	NA	14.60	2.78	NA	36.80	090
22214	.....	A	Revision of lumbar spine	19.45	NA	15.32	2.78	NA	37.55	090
22216	.....	A	Revise, extra spine segment	6.04	NA	3.31	0.98	NA	10.33	ZZZ
22220	.....	A	Revision of neck spine	21.37	NA	15.61	3.65	NA	40.63	090
22222	.....	A	Revision of thorax spine	21.52	NA	15.08	3.08	NA	39.68	090
22224	.....	A	Revision of lumbar spine	21.52	NA	15.70	3.20	NA	40.42	090
22226	.....	A	Revise, extra spine segment	6.04	NA	3.22	1.01	NA	10.27	ZZZ
22305	.....	A	Treat spine process fracture	2.05	3.25	2.01	0.29	5.59	4.35	090
22310	.....	A	Treat spine fracture	2.61	4.77	3.54	0.37	7.75	6.52	090
22315	.....	A	Treat spine fracture	8.84	NA	9.32	1.37	NA	19.53	090
22318	.....	A	Treat odontoid fx w/o graft	21.50	NA	15.02	4.26	NA	40.78	090
22319	.....	A	Treat odontoid fx w/graft	24.00	NA	17.42	4.76	NA	46.18	090
22325	.....	A	Treat spine fracture	18.30	NA	14.94	2.61	NA	35.85	090
22326	.....	A	Treat neck spine fracture	19.59	NA	15.67	3.54	NA	38.80	090
22327	.....	A	Treat thorax spine fracture	19.20	NA	15.43	2.75	NA	37.38	090
22328	.....	A	Treat each add spine fx	4.61	NA	2.43	0.66	NA	7.70	ZZZ
22505	.....	A	Manipulation of spine	1.87	4.58	3.20	0.27	6.72	5.34	010
22520	.....	A	Percut vertebroplasty thor	8.91	NA	4.15	0.99	NA	14.05	010
22521	.....	A	Percut vertebroplasty lumb	8.34	NA	3.92	0.93	NA	13.19	010
22522	.....	A	Percut vertebroplasty addl	4.31	NA	1.75	0.33	NA	6.39	ZZZ
22548	.....	A	Neck spine fusion	25.82	NA	18.08	4.98	NA	48.88	090
22554	.....	A	Neck spine fusion	18.62	NA	13.94	3.51	NA	36.07	090
22556	.....	A	Thorax spine fusion	23.46	NA	16.80	3.78	NA	44.04	090
22558	.....	A	Lumbar spine fusion	22.28	NA	15.27	3.18	NA	40.73	090
22585	.....	A	Additional spinal fusion	5.53	NA	2.94	0.98	NA	9.45	ZZZ
22590	.....	A	Spine & skull spinal fusion	20.51	NA	15.56	3.81	NA	39.88	090
22595	.....	A	Neck spinal fusion	19.39	NA	14.58	3.62	NA	37.59	090
22600	.....	A	Neck spine fusion	16.14	NA	12.66	2.89	NA	31.69	090
22610	.....	A	Thorax spine fusion	16.02	NA	12.98	2.66	NA	31.66	090

[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
22612	.....	A	Lumbar spine fusion	21.00	NA	15.75	3.28	NA	40.03	090
22614	.....	A	Spine fusion, extra segment	6.44	NA	3.54	1.04	NA	11.02	ZZZ
22630	.....	A	Lumbar spine fusion	20.84	NA	16.01	3.79	NA	40.64	090
22632	.....	A	Spine fusion, extra segment	5.23	NA	2.75	0.90	NA	8.88	ZZZ
22800	.....	A	Fusion of spine	18.25	NA	14.30	2.71	NA	35.26	090
22802	.....	A	Fusion of spine	30.88	NA	21.88	4.42	NA	57.18	090
22804	.....	A	Fusion of spine	36.27	NA	24.48	5.23	NA	65.98	090
22808	.....	A	Fusion of spine	26.27	NA	18.27	4.36	NA	48.90	090
22810	.....	A	Fusion of spine	30.27	NA	19.63	4.49	NA	54.39	090
22812	.....	A	Fusion of spine	32.70	NA	21.89	4.67	NA	59.26	090
22818	.....	A	Kyphectomy, 1–2 segments	31.83	NA	21.69	5.01	NA	58.53	090
22819	.....	A	Kyphectomy, 3 or more	36.44	NA	22.19	5.20	NA	63.83	090
22830	.....	A	Exploration of spinal fusion	10.85	NA	10.05	1.73	NA	22.63	090
22840	.....	A	Insert spine fixation device	12.54	NA	6.84	2.03	NA	21.41	ZZZ
22841	.....	B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842	.....	A	Insert spine fixation device	12.58	NA	6.83	2.04	NA	21.45	ZZZ
22843	.....	A	Insert spine fixation device	13.46	NA	7.39	2.10	NA	22.95	ZZZ
22844	.....	A	Insert spine fixation device	16.44	NA	9.26	2.42	NA	28.12	ZZZ
22845	.....	A	Insert spine fixation device	11.96	NA	6.38	2.22	NA	20.56	ZZZ
22846	.....	A	Insert spine fixation device	12.42	NA	6.70	2.26	NA	21.38	ZZZ
22847	.....	A	Insert spine fixation device	13.80	NA	7.08	2.36	NA	23.24	ZZZ
22848	.....	A	Insert pelv fixation device	6.00	NA	3.38	0.88	NA	10.26	ZZZ
22849	.....	A	Reinsert spinal fixation	18.51	NA	14.22	2.87	NA	35.60	090
22850	.....	A	Remove spine fixation device	9.52	NA	8.89	1.51	NA	19.92	090
22851	.....	A	Apply spine prosth device	6.71	NA	3.54	1.11	NA	11.36	ZZZ
22852	.....	A	Remove spine fixation device	9.01	NA	8.60	1.40	NA	19.01	090
22855	.....	A	Remove spine fixation device	15.13	NA	11.67	2.74	NA	29.54	090
22899	.....	C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900	.....	A	Remove abdominal wall lesion	5.80	NA	4.42	0.58	NA	10.80	090
22999	.....	C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000	.....	A	Removal of calcium deposits	4.36	9.04	6.97	0.50	13.90	11.83	090
23020	.....	A	Release shoulder joint	8.93	NA	10.53	1.23	NA	20.69	090
23030	.....	A	Drain shoulder lesion	3.43	6.40	4.44	0.42	10.25	8.29	010
23031	.....	A	Drain shoulder bursa	2.74	5.80	4.16	0.33	8.87	7.23	010
23035	.....	A	Drain shoulder bone lesion	8.61	NA	16.13	1.19	NA	25.93	090
23040	.....	A	Exploratory shoulder surgery	9.20	NA	11.71	1.28	NA	22.19	090
23044	.....	A	Exploratory shoulder surgery	7.12	NA	10.73	0.97	NA	18.82	090
23065	.....	A	Biopsy shoulder tissues	2.27	2.61	1.34	0.14	5.02	3.75	010
23066	.....	A	Biopsy shoulder tissues	4.16	8.34	6.16	0.50	13.00	10.82	090
23075	.....	A	Removal of shoulder lesion	2.39	5.40	3.17	0.25	8.04	5.81	010
23076	.....	A	Removal of shoulder lesion	7.63	NA	8.36	0.87	NA	16.86	090
23077	.....	A	Remove tumor of shoulder	16.09	NA	14.41	1.81	NA	32.31	090
23100	.....	A	Biopsy of shoulder joint	6.03	NA	8.73	0.81	NA	15.57	090
23101	.....	A	Shoulder joint surgery	5.58	NA	8.63	0.77	NA	14.98	090
23105	.....	A	Remove shoulder joint lining	8.23	NA	10.18	1.13	NA	19.54	090
23106	.....	A	Incision of collarbone joint	5.96	NA	9.27	0.82	NA	16.05	090
23107	.....	A	Explore treat shoulder joint	8.62	NA	10.41	1.19	NA	20.22	090
23120	.....	A	Partial removal, collar bone	7.11	NA	9.55	0.99	NA	17.65	090
23125	.....	A	Removal of collar bone	9.39	NA	10.78	1.27	NA	21.44	090
23130	.....	A	Remove shoulder bone, part	7.55	NA	9.82	1.06	NA	18.43	090
23140	.....	A	Removal of bone lesion	6.89	NA	8.31	0.82	NA	16.02	090
23145	.....	A	Removal of bone lesion	9.09	NA	10.87	1.24	NA	21.20	090
23146	.....	A	Removal of bone lesion	7.83	NA	10.70	1.11	NA	19.64	090
23150	.....	A	Removal of humerus lesion	8.48	NA	10.14	1.14	NA	19.76	090
23155	.....	A	Removal of humerus lesion	10.35	NA	12.33	1.20	NA	23.88	090
23156	.....	A	Removal of humerus lesion	8.68	NA	10.45	1.18	NA	20.31	090
23170	.....	A	Remove collar bone lesion	6.86	NA	11.33	0.84	NA	19.03	090
23172	.....	A	Remove shoulder blade lesion	6.90	NA	9.59	0.95	NA	17.44	090
23174	.....	A	Remove humerus lesion	9.51	NA	11.74	1.30	NA	22.55	090
23180	.....	A	Remove collar bone lesion	8.53	NA	16.16	1.18	NA	25.87	090
23182	.....	A	Remove shoulder blade lesion	8.15	NA	16.18	1.08	NA	25.41	090
23184	.....	A	Remove humerus lesion	9.38	NA	16.43	1.24	NA	27.05	090
23190	.....	A	Partial removal of scapula	7.24	NA	8.74	0.97	NA	16.95	090
23195	.....	A	Removal of head of humerus	9.81	NA	10.03	1.38	NA	21.22	090
23200	.....	A	Removal of collar bone	12.08	NA	14.39	1.48	NA	27.95	090
23210	.....	A	Removal of shoulder blade	12.49	NA	13.96	1.61	NA	28.06	090
23220	.....	A	Partial removal of humerus	14.56	NA	15.57	2.03	NA	32.16	090
23221	.....	A	Partial removal of humerus	17.74	NA	16.93	2.51	NA	37.18	090
23222	.....	A	Partial removal of humerus	23.92	NA	20.66	3.37	NA	47.95	090
23330	.....	A	Remove shoulder foreign body	1.85	6.15	3.49	0.18	8.18	5.52	010
23331	.....	A	Remove shoulder foreign body	7.38	NA	9.70	1.02	NA	18.10	090
23332	.....	A	Remove shoulder foreign body	11.62	NA	12.12	1.62	NA	25.36	090
23350	.....	A	Injection for shoulder x-ray	1.00	7.22	0.35	0.05	8.27	1.40	000

[1] CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.